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# A Phenomenological Investigation of Counselor Competencies in Working with Children Diagnosed with Autism Spectrum Disorder and their Families

Katherine A. Feather  
*University of South Carolina*

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A PHENOMENOLOGICAL INVESTIGATION OF COUNSELOR  
COMPETENCIES IN WORKING WITH CHILDREN DIAGNOSED WITH  
AUTISM SPECTRUM DISORDER AND THEIR FAMILIES

by

Katherine A. Feather

Bachelor of Arts  
Cleveland State University, 2009

Master of Arts  
University of Akron, 2012

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Accepted by:

Joshua M. Gold, Major Professor

Ryan G. Carlson, Committee Member

Kerry R. Lachance, Committee Member

Payal Shah, Committee Member

Cheryl L. Addy, Vice Provost and Dean of the Graduate School

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## DEDICATION

This work is dedicated to my grandparents, Thomas Bartoszek, Doreen Bartoszek, Margaret Price, and William Feather II, who all believed in the power of education and supported me to follow my dreams, thank you.

## ACKNOWLEDGEMENTS

To my chair, Dr. Joshua Gold, I thank you for your support and encouragement over the past three years. You believed in me before I believed in myself. To my committee members, Dr. Ryan Carlson, Dr. Kerry Lachance, and Dr. Payal Shah, thank you for contributing to my growth as a scholar. Your expertise, encouragement, and honesty was truly invaluable throughout this entire process. To my family, friends, mentors and Nick, I love you and thank you all for everything. Finally, to the fifteen counselors who shared their experiences; I will never forget your extraordinary commitment to your work and your willingness to share your wisdom, thank you.

## ABSTRACT

Autism spectrum disorder (ASD) is a profound diagnosis that affects 1% of the world's population (Centers for Disease Control and Prevention [CDC]; 2015a). Counselors can play a dynamic role in treating ASD and promoting greater life satisfaction; however, the counseling field has not identified how counselors develop their competencies working with children with ASD and their families. Therefore, the phenomenological investigation examined the experiences of 15 counselors in the field and their self-perceived competencies of treating ASD. A model of ASD counseling competencies development emerged from the data. Participants described the developmental components of Multicultural and Social Justice Counseling Competencies (MSJCC; Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016) such as building awareness, knowledge, skills, and action competencies. By gaining exposure to the diagnosis, the cyclical, developmental process of MSJCC built their clinical expertise. Additionally, analysis illustrated participants increased their competence by describing a strong counseling identity, professional orientation, and personal characteristics to meet the needs of the child and their family. To better serve this ever-increasing population, implications for counselor education, supervisors, and professional counselors is presented.

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## LIST OF ABBREVIATIONS

ABA .....	Applied Behavioral Analysis
ACA .....	American Counseling Association
AMCD.....	Association for Multicultural Counseling and Development
APA.....	American Psychiatric Association
ASD.....	Autism Spectrum Disorder
CACREP .....	Council for Accreditation of Counseling and Related Educational Programs
CDC .....	Centers for Disease Control and Prevention
CRC.....	Certified Rehabilitation Counselor
CSC.....	Certified School Counselor
DSM.....	Diagnostic and Statistical Manual of Mental Disorders
HFA.....	High-Functioning Autism Spectrum Disorder
LFA.....	Low-Functioning Autism Spectrum Disorder
LMFT .....	Licensed Marriage and Family Therapist
LPC .....	Licensed Professional Counselor
MCC.....	Multicultural Counseling Competencies
MSJCC .....	Multicultural and Social Justice Counseling Competencies
SLP.....	Speech-Language Pathologist
SPC .....	Self-Perceived Competencies

# CHAPTER 1

## INTRODUCTION

### **Counselor Competence**

The leading counseling organizations (e.g., the American Counseling Association [ACA]; 2014 and the Council for Accreditation of Counseling and Related Educational Programs [CACREP]; 2016) have recognized the counseling competencies required to license counselors-in-training, as well as the ethical obligation to continue to enhance competencies. The ACA (2014) governing council recently published an updated version of the *Code of Ethics*. What continues to be the professions primary responsibility is to respect the dignity and promote the welfare of clients (ACA, 2014, Standard A.1.a.). To ensure client welfare is the professions highest priority, counselors must demonstrate their competence and ability to provide adequate counseling services (ACA, 2014; CACREP, 2016).

Defining counselor competence is a difficult task because it is a complex, multidimensional construct (Sommers-Flanagan, 2015). Typically, competence is recognized as having skills, professional dispositions, behaviors (Swank & Lambie, 2012), as well as the exercise of judgment (Bernard & Goodyear, 2014) to be considered capable in contributing to positive client outcomes (Sommers-Flanagan, 2015). To foster counselor competence in counselor education programs, CACREP (2016) established critical, knowledge-based principles and requires programs to integrate standards into their curricula (Swank & Lambie, 2012). Further, competency standards are used for

accreditation to evaluate the success of the program (Swank & Lambie, 2012), combat student impairment (Rust, Raskin, & Hill, 2013), and contribute to student-learning outcomes and assessment (Barrio Minton & Gibson, 2012).

In addition, scholars have designed standardized, comprehensive assessments measuring counselor competency to evaluate some aspect of performance such as knowledge, skills, and ethical counseling (Tate, Bloom, Tassara, & Caperton, 2014). Such instruments include: (a) Counseling Competencies Scale (CSS); (b) Counseling Skills Scale (CSS); and (c) Basic Skills Evaluation Device (BSED). In total, there are 41 psychometric instruments available for counseling programs that measure counselor competence (see Tate et al., 2014). Accordingly, accrediting organizations, licensing boards, and counseling organizations have outlined specific counseling competencies favored to work in the field. Even though the profession has implemented safeguards to ensure competent counselors in the field, the Association for Multicultural Counseling and Development (AMCD), a division of ACA, called for multicultural counseling competencies (MCC) as a context specific concept (Sue et al., 1982).

### **Multicultural Counseling Competence**

AMCD was founded in 1972 when ACA recognized the need for an organization that focuses on human diversity and multicultural nature of society. AMCD (n.d.) promotes the appreciation, awareness and understanding of the unique cultures and the advancement of the multicultural counseling field. A major contribution of AMCD is the development of MCC for counselors working with clients from varied cultural backgrounds (Arredondo et al., 1996; Sue, Arredondo, & McDavis, 1992; Sue et al., 1982). Sue et al. (1982) first acknowledged the need for MCC and expanded the

Tripartite Model of Cross-Cultural Competence to reform training. As a result, the MCC model requires counselors to: (a) reflect and increase personal *awareness* of values and biases; (b) acquire *knowledge* related to their clients' cultural background; and (c) apply culturally appropriate *skills* and interventions when working with diverse populations (Holcomb-McCoy & Myers, 1999; Sue et al., 1992). Currently, there are 13 psychometric instruments that are context specific to measuring MCC and are typically used in counselor education (see Tate et al., 2014).

Scholars in the multicultural counseling field promoted specific MCCs that have been adopted by professional training standards and higher education (Cartwright & Fleming, 2010; Cook, Hayden, Gracia, & Tyrrell, 2015; Holcomb-McCoy & Myers, 1999; Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016). The value in training culturally competent counselors has been empirically validated around one's personal awareness, knowledge and skill to meet the needs of culturally diverse clients (Chao, 2013; Collins & Arthur, 2010; Constantine, 2001; Constantine, 2002; Ivers, Johnson, Clarke, Newsome, & Berry, 2016; Ivers & Villalba, 2015; Johnson & Williams, 2015; Quinn, 2012; Rogers-Sirin, Melendez, Refano, & Zegarra, 2015). CACREP (2016) requires programs to adhere and integrate diversity training into the curricula. Further, ACA (2014) has also addressed the need for cultural competence in the *Code of Ethics* standards. Characteristically, MCC is a multifaceted process and may develop during one's pre-post educational training (Barden & Greene, 2015). Naturally, the counseling profession has placed disability competencies under the MCC model. However, counseling and related fields have identified specific competencies needed to counsel those with a disability.

## **Disability Counseling Competence**

Persons with disabilities are recognized as a “multicultural concern” (Smith, Foley, & Chaney, 2008), but researchers have acknowledged distinct disability competencies clinicians’ must possess to work with this clientele (Artman & Daniels, 2010; Chan, Leahy, Saunders, Tarvydas, Ferrin, & Lee, 2003; Gilson & DePoy, 2002; Gourdine & Sanders, 2002; Kemp & Mallinckrodt, 1996; McClean, 2008; Strike, Skovholt, & Hummel, 2004; Weiss, Lunskey, & Morin, 2010). However, counseling and related fields identified how persons with disabilities have their own distinct characteristics and may not fit under a multicultural framework, which may oversimplify their circumstances (Artman & Daniels, 2010). Hence, focusing on disability competence can contribute to improving quality services in the mental health profession (Strike et al., 2004).

## **Autism Spectrum Disorder Counseling Competence**

Counselors are gradually recognizing persons with disabilities as a population we must serve (Smart & Smart, 2006) and be competent in serving (Thomas, Curtis, & Shippen, 2011). In particular, the developmental disability, autism spectrum disorder (ASD), is a diagnosis that is on the rise (CDC; 2015a) and many counselors across disciplines will see in practice. Accordingly, counseling professionals must demonstrate competencies when working with ASD. Yet, the counseling profession has not specified the development, as well as the counseling competencies required to counsel individuals and families diagnosed with ASD. Not only is it critical to address the knowledge and skills needed to treat children with ASD and their families, but also it is essential to

understand the diagnostic history of ASD and how the counseling profession falls short of competently treating this diagnosis.

ASD was first incorporated as a separate category in the *Diagnostic and Statistical Manual of Mental Disorders* (3<sup>rd</sup> ed.; *DSM-III*, American Psychiatric Association [APA], 1985) when it was called ‘infantile autism’ and was later changed to ‘autistic disorder’. Asperser’s syndrome was added to the *DSM-IV* (4<sup>th</sup> ed.; APA, 1994) and was removed in the *DSM-5* (5<sup>th</sup> ed.; APA, 2013). According to the recent revision, the *DSM-5* classifies ASD on a single spectrum, which better reflects symptom depiction from low-functioning ASD (i.e., LFA) to high-functioning ASD (i.e., HFA; Kaufmann, 2012).

Even though ASD was incorporated in the *DSM-III*, the counseling profession has yet to recognize competencies to treat this diagnosis. However, related helping professions (i.e., speech-language pathology and social work) have begun to establish the competencies needed to work with children diagnosed with ASD (Burnett, 2014; Cascella & Colella, 2004; Dinecola & Lemieux, 2015; Glennon, 2016; Plumb & Plexico, 2013; Schwartz & Drager, 2008; Werner, 2011). Presently, the counseling field has not identified how counselors develop their competencies to work with this diagnosis, as well as the specific ASD counseling competencies considered necessary to treat the diagnosis. Thus, this dissertation will address the how professional counselors’ developed their ASD counseling competencies. In addition, the counseling competencies needed to treat ASD based on counselors’ self-perceived competencies (SPC) related to their awareness, knowledge and skill.

## **Statement of Problem**

### **Background of Problem**

ASD is a complex developmental disorder that affects the lives of children and their families in ever-increasing numbers. The CDC (2015b) recognized ASD as a significant public health concern that must be addressed by the counseling field (Feather, 2016). According to the latest statistics, 1 in 68 children are diagnosed with ASD, which is 30% higher than the 2012 findings (CDC; 2015b). Furthermore, the CDC (2013) released a comprehensive report that identified the leading diagnosis among children in order of prevalence: attention-deficit/hyperactivity disorder, behavioral conduct problems, anxiety, depression, and ASD. Hence, accurate diagnosis and the use of effective clinical interventions are vital to the treatment of ASD (Feather, 2016). For counselors to engage in successful treatment outcomes, one has to be deemed competent to treat the diagnosis (ACA, 2014, Standard C.2.a.). More specifically, with regard to specialty areas of practice, ACA (2014) *Code of Ethics* clearly states, “Counselors practice in specialty areas, counselors take steps to ensure the competence of their work and to protect others from harm” (Standard C.2.b.).

### **Problem Statement**

Consequently, the profession has not explored how counselors’ develop their ASD counseling competencies, as well as the counseling competencies needed to treat children diagnosed with ASD and their families. Based on the literature reviewed from various disciplines (i.e., speech-language pathology and social work), there are specific competencies required to treat children on the autism spectrum. Perhaps, one might wonder: (a) do these competencies stem from the counselors’ life experiences; (b) are



these competencies fostered by academic and/or clinical experiences from one's educational training; or (c) do these competencies flourish during post-graduate experiences? For the purposes of this study, these three periods are designated as counselors' SPC. Accordingly, based on the multicultural counseling field and the established MCC model, I will pull from the empirically-based MCC standards to drive the current study and tie these standards to counselors' SPC working with ASD.

### **Nature of Study**

The function of this dissertation is to gain a clearer understanding of counselors' SPC to work with children diagnosed with ASD and their families. Counselors' experiences will be coupled with the MCC standards based on participants' awareness, knowledge, and skills when treating children on the autism spectrum. Thus, the research questions that will drive the current study are:

RQ1: How do counselors describe their experiences counseling children diagnosed with ASD and their families?

RQ2: How do counselors describe their development of clinical competence working with children diagnosed with ASD and their families?

The research questions will be examined utilizing a systematic procedure of capturing rich descriptions of phenomena and meaning participants make of experiences when working with children on the autism spectrum and their families (Groenewald, 2004). A more detailed discussion of the methodological design will be reviewed in Chapter 3.

### **Purpose of Study**

The purpose of the study is to explore the developmental components of SPC of counselors working with children diagnosed with ASD and their families. I will pull from

the MCC literature as an established theory to measure competencies when counseling the child with ASD and their family. Based on the literature, developing into a multiculturally competent counselor is a multifaceted process that requires counselors to: (a) reflect and increase personal *awareness* of values and biases; (b) acquire *knowledge* related to their clients' cultural background; and (c) apply culturally appropriate *skills* and intervention when working with diverse clients (Sue et al., 1992). In addition, I will explore the counselors' SPC (i.e., life experiences, educational and clinical training experiences, and the post-graduate experiences). The designated periods may provide a thorough conceptualization of how counselors acquire competencies working with children diagnosed with ASD. Therefore, the dissertation hopes to answer what competencies do counselors deem critical when working with children diagnosed with ASD and their families. Further, how counselors describe their ASD counseling competencies development to work with the diagnosis. Based on the participants' responses, the self-perceived preparedness may speak to the academic and clinical training literature, as well as implications for supervision and counseling practice.

### **Theoretical Framework**

Qualitative research seeks to make sense of actions and narratives of research participants (Glesne, 2016), as well as attempts to understand and interpret phenomenon in terms of the meaning participants bring to them (Denzin & Lincoln, 2013). From a post-positivist perspective, subjectivity is defined as understanding the point of view of the other person, while also being cognizant of whose "voice" is being constructed within the research (Allison & Pomeroy, 2000; Denzin & Lincoln, 2013). The purpose of this study is to understand the experience from the participant's view; thus, the constructivist

paradigm fosters this approach. The constructivism assumes “a relativist ontology (there are multiple realities), a subjectivist epistemology (knower and responder co-create understandings), and a naturalistic set of methodological procedures” (Denzin & Lincoln, 2013, p. 27). As opposed to objectivism, the constructivist paradigm aims to comprehend the structuring of the individual’s world at the micro level; thus, the research is shared in order to ensure knowledge is reflective of the subjects’ reality (Denzin & Lincoln, 2013). Aligning with the constructivist paradigm allows researchers to become a “passionate participant” as a multi-voice reconstruction of the experience, recognize the interplay of parts, and appreciate the participant as a “whole” person (Denzin & Lincoln, 2013). Therefore, by engaging in constructivism, the researcher and participant can become partners in the generation of meaning (deMarrais & Lapan, 2004).

Phenomenological methodology couples with the constructivist paradigm and explores the perceptions and experiences of any given phenomenon (Glesne, 2016). Phenomenological design investigates how participants’ make sense of such experiences, as well as seeks to examine similarities and differences across cases (Glesne, 2016). Hays and Wood (2011) affirmed, “Phenomenology is a tradition congruent with counseling... [phenomenology] has strong philosophical underpinnings and... is the ideal approach for understanding common experiences of phenomenon” (p. 291). Drawing from the phenomenological tradition will enhance findings by capturing rich descriptions (Groenewald, 2004) of counselors’ SPC related to their: (a) life experiences; (b) educational and clinical training experiences; and (c) post-graduate experiences to treat children with ASD and their families. These three constructs were connected to the established MCC standards, which center on three main competencies of awareness,

knowledge, and skill. Moreover, I was cognizant to reflect on themes that fall outside of MCC. Additionally, I bracketed my assumptions, utilized reflexivity, focused on the how participants' described the phenomenon, as well as identified major themes of the phenomena (Grbich, 2007).

### **Operational Definitions**

To account for the range of descriptions, the following terms and definitions will be used in this study. I utilized peer-reviewed literature, counseling and federal agencies to generate the operational definitions. For the purposes of this study, the following terms are defined as:

**Autism Spectrum Disorder (ASD):** Is a neurological disorder that: (a) affects brain functioning and negatively shapes the child's social interactions and communication skills across multiple context and can vary in severity; and (b) includes restricted, stereotypical behaviors, interests and activities with varied levels of impairment as the diagnostic criteria (APA, 2013).

**Counselor:** Professional (i.e., licensed professional counselor [LPC], certified school counselor [CSC], and licensed marriage and family therapist [LMFT]) that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals (ACA, n.d.).

**Counselor Competence:** Set of skills, dispositions, and behaviors that support counselors in providing ethical and effective services to clients (Swank & Lambie, 2012).

**Disability:** With respect to an individual — (a) a physical or mental impairment that substantially limits one or more major life activities; (b) a record of such an impairment; or (c) being regarded as having such an impairment (Americans with Disabilities Act [ADA], 2008, 42 U.S.C. § 12102).

**Multicultural Counseling Competencies (MCC):** Counselors' knowledge of different racial and cultural groups, awareness of personal attitudes/beliefs, and ability to use appropriate counseling skills when working with diverse range of cultural groups (Barden & Greene, 2015; Sue et al., 1992).

**Self-Perceived Competence (SPC):** A psychological construct based on self-evaluation of one's effectiveness or capability in specific context. SPC is one's awareness, beliefs, expectancy, or understanding of abilities, skills, or capabilities to be effective in interactions with the environment (Boekaerts, 1991).

### **Assumptions, Limitations, Scope, and Delimitations**

#### **Assumptions**

Qualitative research is a network of basic assumptions and is characterized by the subjective. Further, the researcher holds assumptions that guide the research process (Denzin & Lincoln, 2013). As the principal investigator (PI), I acknowledge some general assumptions. The first assumption is life experiences, educational training, and post-graduate experience enhance counselors' SPC. Additionally, in Chapter 3, I provide the reader my position as the researchers as it relates to my own ASD counseling competencies development. The second assumption is participants in the study will provide reliable responses to the interview questions regarding their SPC. The final

assumption is myself and participants will co-construct knowledge around the phenomenon (Denzin & Lincoln, 2013), which will inform the study.

## **Limitations**

One limitation of qualitative research is the data is filtered through the researchers' lens and personal subjectivity (Denzin & Lincoln, 2013). Thus, it is important to note ontological and epistemological assumptions, as well as bracket my position to the phenomenon (Creswell, 2014). However, my own subjectivity can also inform and be an asset when interpreting the data and understanding the phenomenon from my own experiences as a professional counselor. A second limitation to engaging in phenomenological inquiry is that participants' may have difficulty bracketing their own experiences and assumptions (Hays & Wood, 2011). Another limitation is the data is based on the SPC of counselors. The data cannot be confirmed by the clients receiving counseling services or through feedback from supervisors and/or peers. A fourth limitation of the dissertation is the sample of participants have varying years of experience; thus, intricacies and diverse levels of development may not be detected. Lastly, the data was regionally bound and the findings are not applicable across all disciplines in the field of counseling. A more detailed discussion of limitations can be found in Chapter 5.

## **Scope**

The scope of the study includes counselors' in the field who treat children and their families diagnosed with ASD. The data was generated from the experiences of 15 participants in the counseling field and will be bound to that place and time, but may

deepen understanding of this phenomenon. The SPC that materialized from the interviews cannot be generalized, but the descriptive interpretation and categories that emerged may resonate with counselors outside this context.

### **Delimitations**

There are three main aspects to delimitation of this study. First, this dissertation is bound to the counseling field. Secondly, this study is bounded by participants' range of experience counseling children on the autism spectrum and their families. Lastly, this dissertation is delimited to only counselors (i.e., CSC, LPCs, and LMFTs) who work with children and families diagnosed with ASD.

### **Significance of Study**

#### **Knowledge Generation**

Sue et al. (1992) argued the need for MCC, which has been endorsed by ACA and CACREP. Scholars in counseling and related fields have identified specific counseling competencies needed to treat persons with a disability (Artman & Daniels, 2010; Chan et al., 2003; Gilson & DePoy, 2002; Gourdine & Sanders, 2002; Kemp & Mallinckrodt, 1996; McClean, 2008; Strike et al., 2004; Weiss et al., 2010). Literature on specific ASD counseling competencies, as well as ASD counseling competencies development has not been examined or considered. Though, helping professions outside of counseling have addressed certain competencies when working with children on the autism spectrum. After an exhaustive search of the counseling literature, I was unable to obtain a study investigating the competencies needed to treat children with ASD and their families. Therefore, it is the aim of this phenomenological inquiry to investigate counselors' SPC

when working with children diagnosed with ASD and their families and capture this phenomenon.

### **Professional Application**

As previously indicated, counselor competencies treating children with ASD and their families is not addressed in the counseling literature. Thus, the development of counselor competencies around treating the individual and family with ASD is critical due to the prevalence of the diagnosis. Further, identifying the developmental components that include awareness, knowledge and skill will prove essential to scholars, counselor educators, and supervisors to enhance counselor training and standards. Currently, the counseling field has not identified developmental and specific competencies to treat children diagnosed with ASD and their families; hence, are counselors duly qualified to work with ASD? Due to the complexity of the disorder, counseling the child, as well as the family diagnosed with ASD can be a difficult task, especially when symptoms and characteristics are broad (Feather, 2016). Thus, it is imperative for the counselor educators and supervisors to integrate findings of the study to inform training so students can increase their awareness, knowledge, and skills to foster effectiveness with ASD.

### **Social Change**

I anticipate the outcomes of the study will foster counselors' work with children diagnosed with ASD and their families within the counseling room, as well as in supervision with developing counselors. Historically, the field of counseling has had minimal involvement as it relates to the research and treatment of children with ASD



(Feather, 2016). Thus, establishing the basic competencies needed to treat children on the autism spectrum and their families will develop counselors' awareness, knowledge, and skills, as well as influence counselor education programs. Finally, I foresee the study being replicated to validate the findings through other qualitative and quantitative approaches.

## **Conclusion**

Counseling organizations and licensing boards have endorsed and identified specific standards needed to provide counseling services to clients. Over the last three decades, leaders in the multicultural counseling field have addressed the need for MCC, which has had a profound impact on training and counselor preparedness. In addition, scholars have recognized the distinct competencies needed to measure self-awareness, perceived knowledge, and perceived skill of counseling persons with a disability. What the counseling profession has not examined is how counselors develop their competencies to work with this specific diagnosis. In addition, the counseling professional has not addressed the counseling competencies required to work with children diagnosed with ASD and their families. With the diagnosis on the rise, many counseling professionals will be faced with the joys and challenges of working with children on the autism spectrum and their families (Feather, 2016). Thus, this phenomenological investigation hopes to fill this gap in the literature and attend to counselors' SPC to work with this ever-increasing diagnosis. The following chapters include a literature review (Chapter 2); overview of research methodology and design (Chapter 3); results of data (Chapter 4); and the study's findings with implications and recommendations for future research will be discussed (Chapter 5).

## CHAPTER 2

### LITERATURE REVIEW

This chapter provides a comprehensive review of the literature as it pertains to the development of: (a) counselor competence; (b) MCC; (c) disability competence; and (d) ASD competence. All literature included in the review was obtained through searches on EBSCO (Academic Search Complete) and Google Scholar. Terms used in searches included: counselor competence, multicultural competence, disability competence, ASD, and counselor education. Since there was a shortage of literature available on competencies related to disability and the treatment of children with ASD and their families, the review also includes articles from psychology, rehabilitation counseling, social work, and speech-language pathology. I searched between the years 2016 to 1982. The review begins with the construct definition, theoretical scholarship on counselor competencies than a chronological review of both quantitative and qualitative empirical evidence for how counselors or those in closely related fields develop competencies. Finally, the review concludes with the purpose of the present study.

#### **Construct Definition**

**Counselor competence.** The counseling profession has outlined specific counseling competencies required to work with clients (CACREP, 2016; Sommers-Flanagan, 2015). Demonstrating competence guides ethical principles and leads to positive client outcomes (Sommers-Flanagan, 2015; Rust et al., 2013). Counselors must

maintain such standards (ACA, 2014; CACREP, 2016), which coincide with counselor competence (Sommers-Flanagan, 2015). Counselor competence is defined as a set of skills, professional dispositions, and behaviors in the delivery of effective services to meet the needs of clients (Swank & Lambie, 2012). In addition, Bernard and Goodyear (2014) acknowledged, “competence is not merely a disparate collection of knowledge and skills, but rather something that requires exercise of judgment” (p. 7). Thus, counselor competence is a complex, multidimensional construct (Sommers-Flanagan, 2015); however, scholars in the multicultural counseling field promoted explicit MCC (Holcomb-McCoy & Myers, 1999; Sue et al., 1992) that have been adopted by professional training standards and higher education (Cook et al., 2015; Ratts et al., 2016).

**Multicultural competence.** In 1982, ACA endorsed MCC and grounded counselor competencies in strength-based, multicultural constructs (Sue et al., 1982). Since the formal acknowledgement of MCC, multicultural counseling perspectives have been embedded in the counseling profession and additional competencies for specific populations have developed (Ratts et al., 2016). MCC has been empirically validated around counselors’ awareness, knowledge and skill to meet the needs of diverse clientele (Ivers et al., 2016; Ivers & Villalba, 2015; Rogers-Sirin et al., 2015). Further, MCC is a multifaceted process and is defined as counselors’ *awareness* of personal attitudes and beliefs, *knowledge* of different cultural groups, and ability to use appropriate counseling *skills* when working with a diverse range of cultural groups (Sue et al., 1992). Even though disability is recognized as a multicultural concern (Smith et al., 2008), scholars have recognized specific competencies needed to counsel those with a disability.

**Disability competence.** Disability is defined with respect to the individual as: (a) a physical or mental impairment that substantially limits one or more major life activities; (b) a record of such an impairment; or (c) being regarded as having such an impairment (ADA, 2008, 42 U.S.C. § 12102). Having a disability can include a myriad of physical, cognitive, sensory, developmental, psychiatric, or multiple conditions (Thomas et al., 2011). How society has been socialized to think and feel about disability affects the quality of life and life satisfaction of persons with disabilities (Thomas et al., 2011). Thus, researchers in several helping professions have identified explicit competencies to assist with the concerns faced by those with a disability (Artman & Daniels, 2010; Gilson & DePoy, 2002; Gourdine & Sanders, 2002; Kemp & Mallinckrodt, 1996; McClean, 2008; Strike et al., 2004; Weiss et al., 2010).

**Autism spectrum disorder competence.** ASD is a developmental disability many counselors across disciplines will see in practice. ASD is characterized by: (a) a persistent deficit in social communication and social interaction across multiple contexts; (b) restricted, repetitive patterns of behaviors, interests, or activities; (c) presence of symptoms in the early developmental period; and (d) clinically significant impairment in social, occupational, or other important areas of current functioning as a result of symptoms (APA, 2013). Based on the ACA *Code of Ethics* (2014, Standard C.2.c.), counselors must be deemed competent to treat a new specialty area of practice; yet, the counseling field has not recognized the counseling competencies needed to treat children with ASD and their families. However, related helping professions have begun to address clinical competencies to treat children on the autism spectrum (Burnett, 2014; Cascella & Colella, 2004; Dinecola & Lemieux, 2015; Glennon, 2016; Plumb & Plexico, 2013;

Schwartz & Drager, 2008; Werner, 2011). Thus, scholars have begun to determine and establish competencies to inform treatment for this diverse diagnosis.

## **Theoretical Articles**

### **Counselor Competence**

McLeod's (1992) paper explored counselor competencies and how to assess one's competence. McLeod summarized the importance of counselor competence as a means to practice effectively and demonstrate knowledge and skills. McLeod defined 'counseling skill' as an "observable sequence of behavior which forms one competent of the overall performance of 'counseling'" (p. 360). The author promoted the term 'competence' as "qualities or abilities of the person which contribute to effective performance of a role or task" (p. 360). Further, McLeod argued competence is an inclusive notion and promotes other relevant characteristics of the counselor to emerge.

**Sources of assessment information.** McLeod argued there are several forms of evaluation when assessing counselor competence. One is a supervisor's appraisal as an external judge of competence. The second is the SPC of the counselor. Lastly, McLeod acknowledged clients themselves might be willing to assess the competence of the counselor through formal or informal assessments. The different sources of competence may represent contrasting perspectives each with its own indicative insights and "blind spots."

**Techniques for assessing counselor competence.** McLeod outlined several scales counselors can use to assess counselor competence. Such rating scales assess various aspects of the counselors' skills and encompass an evaluative function of how 'good' a counselor is; for example, exuding empathy. Additionally, McLeod suggested

supervisors and counselors utilize video and audiotapes to assess counselor performance. Further, the author encourages the use of role-plays within supervision and/or with peers, as well as utilizing a journal. McLeod delineated how journals can include elements such as “personal development, learning arising from course activities, application of new skills and insights to practice” (p. 367). Lastly, the author recognized the importance of tests within training courses to provide a formal examination. However, tests merely address dimensions of cognitive skill and knowledge rather than interpersonal skills when working with clients.

**General issues in assessing counselor competence.** McLeod discussed how there is a limited amount of systematic research on how best to assess counselor competence. Moreover, what does exist (e.g., assessments, supervisor ratings, journals) rely on honesty and openness of the supervisee; thus, a culture of safety and support must be established. In addition, resistance to assessment may also be a concern due to the developmental level of the supervisee. McLeod asserted, “Counselor assessment does not operate within an emotionally neutral, rational domain... there is much potential for hurt, competitiveness, and defensiveness... assessment procedures [must] be open to dealing and acknowledging the feelings [of the supervisee]” (p. 365). Finally, McLeod recognized the lack of assessment measuring relevant counseling competencies and suggested that “the measure used to assess the competence of counselors needs to be based more on critical analyses of actual work done by clinicians and less on hypothetical constructs related to clinical theories” (p. 367).

McLeod’s article is dated, but offers numerous implications and recommendations for the counseling field. However, there are several topics absent from his commentary.

First, McLeod suggested a systematic appraisal of counselor competence, but did not provide the constructs of competence. In spite of this, the current study will address three areas of MCC (e.g., awareness, knowledge, and skill) and how this relates to counselors' competencies treating ASD. Secondly, McLeod's article focused on both objective and subjective measurements of counselor competence and did not recognize how subjective assessments could position counselor competencies. Therefore, this research study will foster the subjective (Denzin & Lincoln, 2013) and encourage participants to relay their experiences working with children on the autism spectrum, as well as how their expertise may be built overtime. Lastly, McLeod acknowledged the need for assessments that are grounded in clinical competencies versus counseling theory. The current study will address this by examining the clinical counseling competencies needed to treat children with ASD based on the SPC of counselors.

Sommers-Flanagan (2015) noted that counselor competence is unavoidably multifaceted and multidimensional. Professional definitions of competence rely on conceptual knowledge and typically; it can be difficult for counselors to apply in practice. The author asserted, competencies and standards have been addressed by leading organizations in the counseling field; yet, this myriad of "standards to how mental health counselors should act in the room with clients is far from intuitive" (p. 96). Thus, Sommers-Flanagan gathered evidence-based practices (EBP) and outlined *practical approaches* that contribute to counselor competence and positive client outcomes.

Sommers-Flanagan described three aspects of EBP that involves "effective clinicians bring[ing] together research knowledge, clinical wisdom and skill, and client sensitivity" to session (p. 98). EBP's are grounded in ethical practice and multicultural

sensitivity; therefore, counselors must abide by the ACA *Code of Ethics* (2014), as well as embrace MCC in practice. Sommers-Flanagan further outlined the importance of emphasizing the therapeutic relationship and coinciding this concept with EBP and counselor competence. Fostering the therapeutic relationship is empirically supported and enhances treatment outcomes. Thus, Sommers-Flanagan discussed eight evidence-based relationship factors that adhere to EBP principles and support counselor competence.

Sommers-Flanagan identified eight evidence-based relationship factors that include: (a) congruence and genuineness; (b) the working alliance; (c) unconditional positive regard or radical acceptance; (d) empathic understanding; (e) rupture and repair; (f) managing countertransference; (g) implementing in- and out-of-session procedures; and (h) progress monitoring.

*Congruence and genuineness* embraces unconditional positive regard and empathic understanding and should coincide with client goals. Congruence implies honesty and openness and has shown to be effective when working with diverse clientele. The *working alliance* is pan-theoretical and supports an emotional bond, counselor-client goal agreement, and task collaboration. *Unconditional positive regard* or *radical acceptance* involves accepting each aspect of the client's experience and recognizing discrepancies between what the counselor thinks and what the client thinks is right. Further, counselors should cultivate client acceptance and stress authenticity. *Empathic understanding* is the basic counseling skill such as communicating empathy by paraphrasing, reflecting feelings, interpretation, and validating feelings in addition to the client's appraisal of the counselor's empathic demeanor. *Rupture and repair* stresses the importance of recognizing tensions within the therapeutic relationship and



acknowledging them in session. *Managing countertransference* is essential to distinguish when the counselor is reacting (e.g., emotionally and/or behaviorally in session) to the client. The author notes, “Counselors are more effective when they are aware and deal with their own unresolved emotional and behavioral reactions” (p. 105). *Implementing in- and out-of-session procedures* consisted of proponents of EBP procedures in session with clients (i.e., relaxation techniques, exposure, problem-solving). Lastly, *progress monitoring* is the formal or informal check-ins with clients, as well as measuring client outcomes.

Sommers-Flanagan emphasized the importance of integrating EBPs and encouraged counselors to embrace the above components of counselor competence. He argued the eight relational factors align with the counselors’ professional identity and are easier to embrace as a profession versus the complex standards addressed by leading organizations in the field.

Sommers-Flanagan argued fostering a relational approach with clients, while also integrating EBPs. Relational and strength-based methods have been validated across diverse populations and are an effective treatment (Sharf, 2008). Even though the author embraced MCC, he did not offer which diverse populations respond to relationally oriented EBPs. Therefore, the current study hopes to address this gap by outlining the specific counselor competencies to treat children diagnosed with ASD. Given the person-centered approach promotes MCC (Quinn, 2012); participants in the current study may integrate this method when counseling those on the autism spectrum.

## Multicultural Competence

Sue et al. (1982) were among the first scholars to argue the need for MCC and integrate a multicultural perspective into training, practice, and accreditation standards. Through the position paper, the authors developed what is now known as the tripartite model of cross-cultural counseling competence. The purpose of the position paper was to: (a) identify and challenge common myths and misconceptions of the “culturally different;” (b) define the term *cross-cultural counseling*; and (c) recommend specific cross-cultural counseling competencies.

The authors outlined how many of the myths fostered an individualistic, person-blame orientation that minimizes the system(s) clients engage in on a daily basis. Secondly, the authors defined *cross-cultural counseling* as, “any counseling relationship in which two or more of the participants differ with respect to cultural background, values, and lifestyle” (p. 47). Lastly, D.W. Sue and colleagues argued a culturally competent counselor must possess cultural awareness and beliefs, cultural knowledge, and cultural skills to competently treat diverse clientele.

While the position paper by Sue et al. is a milestone for MCC and recognizing the importance of cross-cultural counseling, limitations must be noted. Sue et al. theoretical framework lacked research to back the claim that if counselors’ mastered MCC, they will be effective with their clients. However, the position paper was the first to recognize the development of MCC; thus, the conceptual framework would lack empirical rigor. Nevertheless, the MCC movement possesses intuitive appeal and has been empirically validated since the development of MCC. Therefore, the current study will continue to

uphold a strong rigor throughout the study to substantiate MCC and correlating this to SPC of counselors treating children with ASD.

Sue et al. (1992) promoted the tripartite model of cross-cultural competence (see Sue et al., 1982) and published the MCC framework. The purpose of the article was to: (a) provide a rationale for a multicultural counseling perspective; (b) propose MCC for counselors; and (c) advocate for specific multicultural strategies and standards. The authors provided a rationale for a multicultural perspective, which included the diversification of the United States, monocultural nature of training, sociopolitical reality, multicultural conceptualizations, research, and ethical priority. Next, the authors offered three dimensions of MCC. First, “a culturally skilled counselor is one who is actively in the process of becoming aware of his or her own assumptions about human behavior, values, biases, preconceived notions, personal limitation, and so forth” (i.e., beliefs and attitudes, p. 481). Second, “a culturally skilled counselor is one who actively attempts to understand the worldviews of his or her culturally different client without negative judgments” (i.e., knowledge, p. 481). Third, “a culturally skilled counselor is one who is in the process of actively developing and practicing appropriate, relevant, and sensitive intervention strategies and skills in working with his or her culturally different clients” (i.e., skills, p. 481). Lastly, the authors promoted the infusion of a multicultural perspective in counseling organizations, education, training, research, and practice.

Sue et al.’s MCC framework was the foundation to incorporate a multicultural perspective into all aspects of the counseling profession. Like Sue et al. (1982) position paper, the Sue et al. article (1992) lacked empirical research to promote the MCC framework. Yet, the fourth revolutionary force (i.e., MCC conceptual model and

multicultural counseling) has been empirically validated since the inception; thus, the current study will maintain a strong rigor throughout the investigation to substantiate MCC, while also associating MCC to SPC of counselors treating children with ASD and their families.

Cartwright and Fleming (2010) outlined the changes to the *2010 Code of Professional Ethics for Rehabilitation Counselors* that focused more specifically on multicultural and diversity-based considerations throughout the code. The authors discussed the importance of cultural competencies and cited Sue et al's (1982) innovative work. Therefore, rehabilitation counselors must understand their values and biases (self-awareness), client's worldviews (knowledge), and intervene in a culturally appropriate manner (skills). Cartwright and Fleming (2010) offered several reasons for the inclusion of cultural competence throughout the code. The authors suggested rehabilitation counselors' lack of cultural competence might be a reason why diverse clients did not utilize rehabilitation services. Further, the authors discussed criticism in the rehabilitation field in terms of "lagging behind in providing ethical principles and values that recognize and respect cultural differences" (p. 214). Therefore, throughout the code, Cartwright and Fleming detailed cultural diversity concerns that embrace a cultural approach.

Cartwright and Fleming summarized the changes to the *2010 Code of Professional Ethics for Rehabilitation Counselors* as it relates to the infusion of multicultural and diversity considerations. Because the article is a summary of the code and the authors used Sue et al's (1992) MCC framework, no critique can be formulated.

Collins and Arthur (2010) expanded on previous theoretical conceptualizations of MCC and detailed MCC to enhance counselor development. The authors recognized the complexity of MCC; however, identified MCC is the “foundation of effective and ethical professional practice” (p. 217). Hence, the authors developed their own conceptual model for *culture-infused counseling* that detailed the attitudes, knowledge and skills central to the model. Collins and Arthur factored the foundational concept of personal cultural identity, presented a culture-infused counseling model and competencies, and elaborated on specific competencies as it relates to attitudes, knowledge, and skills.

**Personal cultural identity.** Acknowledging one’s personal cultural identity and awareness is a foundational concept to MCC and applies to both the counselor and the client. Based on the authors conceptualization of MCC, *cultural factors* “represent the group affiliations held by individuals, including gender, ethnicity, physical and mental ability, sexual orientations, religion, language, and social class” (p. 218). *Personal identity factors* focus on within group and intercultural distinctions, which include genetic make-up, developmental trajectory, and socialization. *Contextual factors* are common to everyone as human beings. As Collins and Arthur asserted, “both the counselor and the client, these [cultural, personal identity, and contextual] factors are fluid, dynamic, and interactive” (p. 219). Thus, all interactions between the counselor and the client are multicultural.

**Culture-infused counseling model.** Collins and Arthur identified the limitations of MCC and developed their own model that addresses a wide range of multifaceted personal cultural identities. The three core competency domains of the culture-infused counseling model are: (a) cultural awareness (i.e., the *self* and an active awareness of

individual assumptions, values and biases); (b) cultural awareness (i.e., the *other* and considering the worldview of the client); and (c) a working alliance that is culturally sensitive.

**Culture-infused counseling competencies.** The authors attempted to provide a framework that was inclusive of previous literature (see Sue et al., 1992) and is a current reflection of MCC. In addition, the authors provided a thorough outline of MCC and specific domains for each section. These domains included: (a) Domain I: Cultural Awareness (self); (b) Domain II (other); and (c) Domain III: Culturally sensitive working alliance. Beneath each domain, the authors listed the five core competencies and under each core competency, the authors identified specific attitudes and beliefs, knowledge, and skills.

Collins and Arthur's MCC framework specified how to practically infuse MCC into counseling practice and training, which has been a significant criticism of previous MCC models (e.g., Sue et al., 1992). However, like preceding evaluations of MCC frameworks, Collins and Arthur did not provide solid empirical validation for their culture-infused counseling model. Therefore, the current study will maintain a strong rigor when engaging in phenomenological inquiry so to validate MCC (i.e., awareness, knowledge, and skills) and connecting MCC to SPC of counselors treating children with ASD and their families (Hays, Wood, Dahl, & Jenkins, 2016).

Grothaus et al. (2012) presented a strength-based approach to MCC and explored its practice in counseling, as well as the means of increasing efficacy and ethical practice. Grothaus et al. defined culture as “encompassing a constellation of factors (e.g., gender,

ability status, race, ethnicity, sexual orientation, socioeconomic status, spirituality)” and considered an essential factor for forming behaviors, attitudes, strengths, beliefs, and values (p. 52). The authors also outlined *advocacy* and the importance of *empowerment* when working with diverse clients. They defined empowerment as, “fostering critical consciousness, facilitating the development of positive identity, and encouraging social action” (p. 59). The authors offered two vignettes of how to infuse MCC and advocacy into practice.

Grothaus et al. provided a comprehensive summary of the current practices of MCC and advocacy, while tailoring it to a strength-based approach. Even though the authors offered two vignettes to demonstrate MCC, advocacy and empowerment, limitations are noted. For example, the authors did not provide their own empirical evidence for how this approach would work for counselors, as well as how clients receive this approach. Therefore, the current study will investigate counselors’ perspectives of their experiences with the phenomenon and how, if at all competencies develop overtime. Further, I will engage in aspects of trustworthiness (Lincoln & Guba, 1985), which may potentially add to the empirical research.

Quinn (2012) shared a historical outline of research and practice of MCC (citing Sue et al., 1992). Further, the author offered a brief outline of person-centered therapy because it is effective across diagnoses and diverse clientele (Rogers, 1961). Empirical MCC research has established *empathy* is an important counselor attribute because counselors are more likely to embrace cultural diversity and “accept the relationship as is -- ambiguous and complex” (p. 214). Quinn outlined the importance of a person-centered approach with diverse clients and the facilitative mechanisms counselors can use in

session (i.e., congruence, unconditional positive regard, and empathic understanding). Therefore, the counselors' "self-congruence (e.g., emotional intelligence) and accurate empathic understanding of the client's internal frame of reference (i.e., empathy was earlier found related to client satisfaction, therapist case conceptualization, and a pro-diversity therapist stance)" offer a culturally competent counseling experience for clients (p. 228). Furthermore, "the effective person-centered therapist must possess multicultural *knowledge* (cognitive empathy) and *awareness* (affective empathy plus self-congruence) to sufficiently provide the *skills* (communication of unconditional positive regard) necessary for a process of change to occur" with diverse clients (p. 229). Thus, if a counselor "can possess a genuine and accepting way of being, then [they] will likely move toward providing these person-centered, culturally adapted facilitative mechanisms of change for the client or family" (p. 236).

Quinn's person-centered framework highlighted the importance of Roger's psychotherapy and how counselors can use the basic concepts to address diverse clients and family needs. However, like previous appraisals of MCC frameworks, Quinn did not provide solid empirical validation for his person-centered approach to MCC. Therefore, the current study will maintain a strong rigor to add to the MCC framework by connecting MCC to SPC of counselors treating children with ASD (Hays et al., 2016).

Ratts et al. (2016) revised and operationalized MCC to include social justice competencies (i.e., MSJCC; Multicultural and Social Justice Counseling Competencies), which have been endorsed by AMCD, as well as ACA. The authors outlined the history of MCC and how it shaped the profession's ethics and other divisions of ACA. Ratts et al. asserted, "the integration of MCC... into the counseling profession has led to viewing



the experiences of historically marginalized groups more holistically, and to philosophical and paradigmatic shifts toward integrating multicultural constructs into counseling practice” (p. 29). Therefore, recognizing the statuses and intersecting identities of clients and how these characteristics shape and contextualize mental health is essential for counselors to comprehend and integrate into practice.

The MCC Revision Committee was charged with: (a) reflecting a more inclusive and broader understanding of culture and diversity that encompasses the intersection of identities and (b) addressing the expanding role of professional counselors to include individual counseling and social justice advocacy. The authors outlined the rigorous revision process, which included an extensive literature review, connecting with professional leaders in MCC, and identifying strengths and gaps within the original MCC document.

MSJCC aimed to be reflective of the lifelong process of competence and counselor development. Further, MSJCC acknowledged important aspects of counseling practice to include: (a) understanding the complexities of diversity and multiculturalism on the counseling relationship; (b) recognizing the negative influence of oppression on mental health and well-being; (c) understanding individuals in the context of their social environment; and (d) integrating social justice advocacy into various modalities of counseling (p. 30-31).

**Intersection of identities: Understanding the complexities of identity.** Ratts et al. emphasized the construction of identity is complex and contributes to the human experience. Additionally, it is important to acknowledge the intersectionality of identities

(e.g., race, ethnicity, gender, sexual orientation, economic status, religion, spirituality, disability status) and the client's environmental influences on which aspects of identity are relevant for an individual at any given moment.

**Oppression and mental health: The influence of oppression on well-being.**

Ratts et al. discussed the issues of oppression exist in the structure of racism, sexism, heterosexism, classism, ageism, ableism, and religious oppression. All forms of oppression manifest and are harmful to both privileged and oppressed individuals. The authors summarized several “dehumanizing” terms such as minority stress, courtesy stigma, and microaggressions that are all based on interpersonal interactions.

**Socioecological perspective: Understanding individuals in the context of their environment.** Ratts et al. acknowledged the importance of counselors' understanding the intersectionalities that influence oppression and the well-being of clients. The authors supported a multilevel approach that includes individual counseling, as well as social justice advocacy outside the counseling session. The authors termed ‘socioeconomical model’ as a framework for counselors to determine if “interventions should occur at the intrapersonal, interpersonal, institutional, community, public policy, and/ or international/global levels” (p. 34).

Ratts et al. outlined the MSJCC conceptual framework; however, for the purposes of the literature review, I will concentrate on the four competencies of attitude and beliefs, knowledge, skills, and action. They summarized the aspirational and developmental competencies as:

First, counselors must possess certain attitudes and beliefs to commit to practicing

counseling and advocacy from a multicultural and social justice framework.

Second, possessing knowledge of relevant multicultural and social justice theories and constructs is necessary to guide multicultural and social justice competence.

Third, multicultural and social justice–informed attitudes, beliefs, and knowledge provide the background for counselors to develop cultural and change-fostering, skill-based interventions. Finally, taking action by operationalizing attitudes and beliefs, knowledge, and skills (AKS) is critical to achieving multicultural and social justice outcomes (p. 38).

The authors maintained the original framework (i.e., AKS); however, the fourth developmental competency, action, is what Ratts et al. believes generates the highest influence on counseling interventions with clients.

Ratts et al. provided a comprehensive framework for the counseling profession to utilize in practice and in counselor education. Moreover, the authors added a new construct (i.e., action) to the framework. However, for the purposes of the present study, I will draw from the former MCC because (a) MSJCC is novel and requires pragmatic support and (b) MCC has substantial empirical evidence related to the competencies needed to treat persons with a disability (see Strike et al., 2004).

### **Disability Competence**

Gilson and DePoy (2002) presented a theoretical approach to disability content in social work education and suggested a shift in how social work curriculum addresses disability. For example, the authors supported a perspective that highlights disability as the interaction of a medical condition with characteristics of an inaccessible environment versus individual deficiency. Therefore, helping professionals must “understand disability

as a multilevel social justice concern embedded within a particular cultural, sociopolitical, economic, and relational environment” (p. 154). The authors suggested two clear ways of conceptualizing disability, which included the diagnostic approach to disability and disability as a construct. The diagnostic approach to a disability is a rehabilitative stance to disability; if the client cannot be “fixed,” then the individual remains deficient. When conceptualizing disability as a construct, disability is viewed as a phenomenon where “disability is seen as a social ‘construction’ rather than a condition which is located ‘with’ an individual” (p. 155). Hence, the disabling environment is a barrier to independence. Typically, disability has been addressed in social work as a diagnostic approach and medical phenomenon. Gilson and DePoy provided a detailed model of how social work programs can integrate a constructivist approach (i.e., disability as a construct) versus emphasizing a diagnostic perspective.

Gilson and DePoy provided an inclusive model that social work programs can utilize to promote disability curriculum. However, the authors did not provide empirical evidence for the disability as a construct approach. Therefore, the current investigation will be an empirically validated study, where strong rigor and elements of trustworthiness will be utilized (Hays et al., 2016; Linclon & Guba, 1985). Based on the themes that emerge from the data through the participants’ voice (Denzin & Lincoln, 2013), the counseling profession can use the findings to promote best-practice when treating children with ASD and their families.

Artman and Daniels (2010) offered a conceptual model of disability that psychologists can utilize in practice. First, the authors describe the historical context of the medical model (i.e., clients must adapt to the environment that does not meet their

needs) and how the psychology field frequently pulls from this perspective. However, Artman and Daniels suggested conceptualizing clients from a *social model of disability*, which focuses on power, resources, and unequal access. The authors stressed how aforementioned factors have limited the amount of evidence-based practices with clients with disabilities.

**Cultural competence with persons with disabilities.** The authors' recognized how 'disability' has fallen under MCC due to the similar historical treatment. For example, persons with disabilities have been under represented in positions of power and have been forced to follow and embrace the values of the majority group. Nevertheless, Artman and Daniels identified how persons with disabilities have their own distinctive characteristics and may "not fit neatly in our multicultural frameworks... and may oversimplify their circumstances" (p.444). The authors provide in detail how psychologists can build their MCC in these four areas, as well as present helpful examples and resources for readers.

Artman and Daniels offered valuable insights and considerations when working with persons with disabilities; yet, limitations must be noted. One major limitation is the authors did not present empirical evidence for the realistic tips when working with persons with disabilities in session. Therefore, the current investigation will be an empirically validated study through elements of trustworthiness (Linclon & Guba, 1985). For example, to obtain credibility, I will be intentionally engage in reflective commentary by bracketing my assumptions before, during, and after data collection so the participants' voice is showcased (Denzin & Lincoln, 2013; Shenton, 2004).

## **Autism Spectrum Disorder Competence**

After a methodical search, I was unable to discover a theoretical article observing ASD competence; however, the current study will fill the gap in the literature.

Additionally, there are a number of implications the current study will acknowledge.

First, through phenomenological inquiry, I hope to add a conceptual framework for ASD counseling competency development the counseling profession can utilize in training and practice. Second, because the dissertation is a qualitative investigation, the subjectivity of participants will ground the research and bring the practicing counselors' "voice" to the forefront (Denzin & Lincoln, 2013). Lastly, this qualitative study will support current research on multicultural competence and/or fall outside of this framework. Thus, it is crucial for this study to examine the competencies needed to treat children with ASD and their families from the perspectives of practicing counselors, which will add to the competency research and provide the counseling profession the first study exploring this phenomenon.

## **Previous Empirical Studies**

### **Quantitative Studies**

#### **Counselor Competence**

Swank et al. (2012) assessed the psychometric properties of the Counseling Competencies Scale (CCS). The CCS is an instrument designed to assess trainee competencies in the areas of skills, dispositions, and behaviors. The authors recognized the lack of comprehensive assessments that appraise counselor competence even though counselor educators and supervisors have an ethical responsibility to be gatekeepers for

the profession. To assess CCS, the researchers chose quantitative methodology and aimed to develop a psychometrically sound instrument by answering the following research questions: (a) *What is the factor loading of the CCS?* (b) *What is the interrater reliability between supervising instructors and supervising doctoral students using the CCS to evaluate counseling students' competencies?* and (c) *What is the relationship between counseling students' scores on the CCS and their academic performance, as measured by the students' final grade in a counseling practicum course?*

**Participants.** The target population consisted of counseling practicum students enrolled in a CACREP-accredited program and their supervisors. Initially, there were eight participating programs; however, only two programs completed the data collection packets. These programs were in the Southeast and Northwest region of the United States. A total of 188 counseling practicum students and 21 supervisors participated in the study.

**Instruments.** The researchers used three instruments for the study. The first instrument was the CCS, while the other two were separate demographic forms for the supervisor and practicum student. The CCS consisted of 32 items and five response categories in rubric form: (a) harmful [0], (b) below expectations [2], (c) near expectations [4], (d) meets expectations [6], and (e) exceeds expectations [8]. The first section of the CCS contained 12 items and required the respondent to review a counseling session and evaluate the trainee's level of competency regarding various counseling skills. The two other sections focused on professional dispositions (e.g., ethics, MCC) and professional behaviors (e.g., knowledge). All sections were assessed over a 15-week semester. The supervisor demographic questionnaire focused on specific areas: (a)

counseling specialty, (b) theoretical orientation, (c) number of times teaching practicum, (d) supervision experience, (e) level of supervision training, and (f) teaching status (e.g., tenured faculty, instructor, or adjunct instructor). The student questionnaire also elicited additional information including: (a) program track, (b) practicum level (for programs requiring two practicum semesters), (c) theoretical orientation, and (d) counseling courses completed.

**Data analysis.** First, the authors screened for missing data and outliers. Additionally, the authors conducted tests to examine normality and linearity. Second, the researchers conducted an exploratory factor analysis to scrutinize construct validity in addition to examining internal consistency reliability utilizing Cronbach's alpha to assess the degree of correlation among items. Third, conducting the Pearson product-moment correlation for each rater monitored the interrater reliability. Finally, by calculating the Person product-moment correlation, the authors examined the criterion-related validity between counseling competence construct and academic performance.

**Results.** For construct validity, the authors specified five criteria for the retention of items throughout the exploratory factor analysis: (a) significant value for Bartlett's test of sphericity; (b) a Kaiser-Meyer-Olkin measure of sampling adequacy value of .50 or above for the overall test; (c) a measure of sampling adequacy value of .50 or above for each item; (d) factor loading of .5 or above; and (e) two or more items loading on each factor. The principal components analysis for the *midterm* data initially yielded a seven-factor matrix. The measure of sampling adequacy for each CCS item exceeded .50, with the lowest value being .784. Therefore, no CCS items were removed based on the measure of sampling adequacy. Each of the four factors were given an appropriate name



based on the items within the factor: (a) Factor One, Professional Behaviors and Dispositions; (b) Factor Two, Assessment and Application; (c) Factor Three, Beginning Counseling Skills; and (d) Factor Four, Advanced Counseling Skills. The principal components analysis for the *final* data yielded a five-factor matrix. The measure of sampling adequacy for each item exceeded .50, with the lowest value being .818. Therefore, no items were removed based on the measure of sampling adequacy. Additionally, no items yielded a factor loading below .5. The screen plot also indicated the presence of five predominant factors. The orthogonal (varimax) rotation for the final set of factors accounted for 72.61% of the total variance. The Cronbach's alpha for the 32 items was .933, indicating a strong correlation. Thus, the five factors were named based on the items contained within the factor: (a) Factor One, Professional Behaviors; (b) Factor Two, Counseling Relationship; (c) Factor Three, Counseling Skills; (d) Factor Four, Assessment and Application; and (e) Factor Five, Professional Dispositions.

The researcher's findings are helpful because they offer a sound, psychometric instrument measuring counselor competence (Tate et al., 2014). However, a few critiques are noteworthy. First, the study initially had eight counseling programs, but only two completed the entire study; thus, sampling limitations must be addressed. Secondly, the results are geographically bound and do not represent the population of counseling students and counselor education programs. Lastly, the CCS does not fully address or align with MCC; therefore, scholars should investigate the relationship between CCS and MCC instruments (see MCCTS; Holcomb-McCoy & Myers, 1999) to see if they correlate with regards to counselor competence. Hence, the current study plans to address MCC as it relates to ASD based on the SPC of counselors in the field.

Tate et al. (2014) were the first to compile the psychometric instruments that have been utilized by counselor educators and supervisors to measure counselor competence. Counselor educators have addressed concerns around counselor achievement and implementation of essential knowledge and skills for students to develop into effective, ethical counselors. The profession has recognized the significance of assessing student performance and preparing entry-level counselors for the profession. In addition, evaluating student performance has been addressed and is required by accreditation standards (CACREP, 2016) and the ACA *Code of Ethics* (2014). Thus, the authors recognized the importance of utilizing psychometric instruments to assess competence as a necessary measure to address student preparedness, as well as honoring the standards of the profession.

Tate and colleagues identified methods to assess student preparedness that include: (a) Counselor Preparation Comprehensive Examination; (b) portfolio-based assessment models; (c) performance appraisal protocols; (d) supervisor evaluations; (e) course-based assessments; (f) exit interviews; (g) alumni surveys; and (h) psychometric instruments. Out of all of these methods, psychometric instruments are an underutilized method of assessment and evaluation. Utilizing psychometric instruments is a “robust method for measuring gains in counseling students’ burgeoning competence... and the use of standardized psychometric instruments provides more reliable and valid assessment data for student evaluation and program assessment” (p. 293). Therefore, Tate et al. considered including assessments in their article that were specifically designed to measure some aspect of counselor competence and were published by refereed sources.

Based on the established inclusion criteria, the authors identified 41 instruments used in 216 published studies. The instruments were separated into two categories: General counseling competence ( $n = 14$ ) or a specific competence domain ( $n = 27$ ). In addition, self-efficacy was the focus of both general ( $n = 4$ ) and specific ( $n = 10$ ) competence instruments.

Based on the results from the literature review, patterns emerged from the counselor competence instruments. For example, one pattern is nearly half of the domain-specific instruments were constructed around MCC (i.e., awareness, knowledge and skills). Secondly, self-efficacy measures accounted for over a third of the instruments in the review. In addition, all of the instruments focused on self-report and only two included client feedback. According to the authors, many of the assessments lacked “a comprehensive, psychometrically sound, and contextually relevant instrument to measure counselor competence... instruments should be developed that are reliable, valid, and relevant to the unique missions and vision of the diverse array of counselor education programs” (p. 303). Therefore, counselor education must continue to develop sound instruments that appraise counselor competence.

The current study will be utilizing a phenomenological approach; as a result, constructs of reliability and validity are measured differently in qualitative research. For the current study, several factors of credibility will be addressed, such as bracketing of my assumptions and engaging in member-checks to ensure trustworthiness of the data (Lincoln & Guba, 1985). A standardized assessment measuring counselor competencies treating children with ASD and their families is warranted, as well as including the client’s perspective so the profession does not “risk creating model[s] of competence that

are at best irrelevant to, and at worst oppressive for counseling clients” (p. 303). Since there is scant empirical research outlining the counselor competencies needed to treat children on the autism spectrum and their families, this study will address the gap and identify suggested competencies. Therefore, the present study will explore the SPC (e.g., self-report) of counselors in the field because there is no measurement available to assess counselor competence treating ASD. The results of the investigation may lead to a follow up study, which may include client and supervisor feedback regarding autism-specific counseling interventions and services.

### **Multicultural Competence**

Holcomb-McCoy and Myers (1999) investigated professional counselors’ perceptions of their MCC and training experiences, as well as what factors constitute to MCC. The authors defined MCC as interpersonal counseling grounded in culture, ethnicity, and race with the focus on three main areas of awareness, knowledge, and skills. The research questions were: (a) *What factors constitute MCC*; (b) *To what extent do professional counselors perceived themselves to be multiculturally competent based on these factors*; (c) *Are there difference between the self-perceived multicultural competence of professional counselors who graduated from counseling program accredited by CACREP and those who graduated from non-CACREP- accredited programs*; (d) *What are counselors’ perceptions of the adequacy of training they have received in multicultural counseling*; and (e) *Is there a relationship between selected demographic factors (e.g., age, gender, ethnicity) and MCC*?

Holcomb-McCoy and Myers stratified a sample of 500 professional counselors from membership through ACA ( $n = 55,281$ ) and AMCD ( $n = 250$ ) based on the racial/ethnic background and date of graduation. A total of 30% ( $N = 125$ ) responded to the survey. The sample was evenly distributed across the regions of ACA and the respondents identified themselves as 66% European/white decent, 19% were African/Black decent, 6% were Latino/Hispanic decent, 5% indicated an Asian or Native American background, and 4% marked 'Other'.

The researchers utilized a researcher-developed instrument, the Multicultural Counseling Competence and Training Survey (MCCTS) "to determine professional counselors' perceptions of their MCC and the adequacy of training" (p. 296). The researchers cultivated 61 items and received feedback on the content and format of the survey. Additionally, the authors sought out leaders in the multicultural field to provide recommendations in addition to piloting the survey on 17 professional counselors. After the items were validated, they were divided into six sections: (a) Multicultural Counseling Curriculum and Entry-Level Program; (b) Faculty and Students in Entry-Level Program; (c) Multicultural Clinical Experience in Entry-Level Program; (d) Postgraduate Multicultural Training and Experience; (e) Demographic Information; and (f) Self-Assessment of MCC and Training. For sections one through four, participants were asked to indicate information regarding their entry-level and postgraduate MCC training experiences and section five included demographic information. Moreover, section six consisted of 32 behaviorally-based statements regarding MCC. Finally, the MCCTS was mailed to 500 potential participants with a cover letter and instructions on how to complete the survey.

**Results.** For research question 1, a principle component factor analysis was calculated, where five factors were extracted with the identification explained by 63% of the variance of the competence items. The authors examined the items associated with each factor and identified Factor 1 as ‘knowledge’ of multicultural concerns, Factor 2 as ‘awareness’, Factor 3 comprised of ‘definitions’ of multicultural counseling terms, Factor 4 defined ‘racial identity development’ and Factor 5 included ‘skill-based’ items.

Research question 2; the researchers examined the descriptive statistics for the factor scores regarding professional counselors’ perceptions of their multicultural competence and found counselors felt most competent on the ‘definitions’ and ‘awareness’ factors and perceived themselves to be less competent on ‘racial identity’ and ‘knowledge’ dimensions. For research question 3, the researchers compared CACREP and non-CACREP-accredited graduates’ self-perceived multicultural competence through a multivariate analysis of variance and found no significant differences, but a significant difference was found on perceptions of training on the ‘knowledge’ factor (research question 4). Research question 5; the authors used a series of multivariate analysis to investigate if there was a relationship between selected demographics and multicultural competence and found race/ethnicity to be the only statistically significant demographic that influenced knowledge, racial identity, awareness, and skills factors associated with MCC.

This study provided a quantitative glance at the relationship between multicultural competence and professional counselors’ training; however, there were several limitations to the study. First, the authors relied on the SPC of participants, which “may reflect respondents’ desire to seem competent rather than otherwise” (p. 298). In addition,

based on the responses, the participants perceived themselves to be multiculturally competent in the areas of awareness and 'definitions'. Conversely, for the current qualitative inquiry, I will utilize MCC defined by one's awareness, knowledge and skills (see Sue et al., 1992) versus what Holcomb-McCoy and Myers found to be MCC (i.e., knowledge, awareness, racial identity development, definitions, and skills). Moreover, I will rely on the SPC of participants counseling those on the autism spectrum because there is no scholarship accessible on this clinical population and how it relates to MCC. Thus, it is important to understand counselors' SPC and receive client feedback in future research. Lastly, the multicultural verbiage used throughout the study is outdated and insensitive. The present study will use up-to-date terminology to describe the phenomena of counselors working with children diagnosed with ASD and their families.

Constantine (2001) observed MCC methods involving actual counseling situations with clients. Thus, the researcher investigated practicum trainees' self-perceived MCC, as well as observer-rated MCC of practicum trainees. The sample included 52 participants, 29 with MA or MS degrees and 23 with BS or BA degrees, who were in the doctoral or master's academic training program and had taken at least one multicultural counseling course. There were 38 women (73%) and 14 men (27%) who ranged from ages 22 to 44 years old ( $M = 29.77$ ,  $SD = 6.07$ ). Participants' racial and ethnic composition included: 31 Caucasian-Americans (60%), 11 Latino-Americans (21%), and 10 African-Americans (19%) with the mean counseling experience of 38.06 months. In regards to the clients, only diverse clients were chosen to participate.

**Instruments.** The Multicultural Counseling Inventory (MCI) is a 40-item, 4-point Likert scale ranging from 1 (very inaccurate) to 4 (very accurate) that assesses MCC and

is built from Sue et al.'s (1992) framework. It measures MCC awareness (i.e., assesses issues such as multicultural advocacy, multicultural interactions and experiences, etc.), MCC knowledge (i.e., multicultural case conceptualization, treatment strategies, etc.), MCC skills (i.e., general multicultural counseling skills), and MCC relationship (i.e., measures aspects of interpersonal processes). From previous investigations, the Cronbach's alpha of .87 has been reported on the entire scale. Next, the Cross-Cultural Counseling, Inventory Revised (CCCI-R) was used in the study to measure third-party assessment of MCC. The CCCI-R is a 20-item, 6-point Likert instrument and is composed of items representing: MCC skill, sociopolitical awareness, and cultural sensitivity. The CCCI-R has been shown to have good content, construct, and criterion-related validity. Lastly, a demographic questionnaire was utilized.

**Procedures.** Participants were recruited through a community counseling clinic, where master's and doctoral students completed their practicum. Students were randomly assigned to clients for a 45-minute audiotaped intake session. Before the preliminary appointment, clients were screened to assess the nature and severity of their presenting problems and were provided the primary purpose of the investigation. After the initial intake session, trainees were asked to fill out the demographic questionnaire, as well as the MCI and were debriefed individually. After, two raters (two doctoral students with extensive exposure to MCC) evaluated the trainees MCC and were unaware of the hypotheses of the research. The intraclass correlation coefficient for the two raters was .84.

**Results.** A multivariate analysis of variance (MANOVA) was conducted ( $p = .05$ ) to determine if trainees varied significantly between previous months of counseling



experience, prior multicultural counseling coursework, MCI full-scale scores, and CCCI-R scores. Constantine found main effect differences for race/ethnicity, Pillai's trace = .72,  $F(8, 88) = 6.21, p < .001$ . More specifically, through a univariate test, significant differences existed on the multicultural counseling course variable,  $F(2, 46) = 12.65, p < .001$ , and the CCCI-R variable,  $F(2, 46) = 37.35, p < .001$ . Furthermore, African-American ( $M = 102.30, SD = 6.85$ ) and Latino-American ( $M = 100.36, SD = 7.89$ ) practicum trainees were rated as having elevated CCCI-R scores than their Caucasian-American ( $M = 70.35, SD = 12.73$ ) counterparts. For the main hierarchical regression analysis, Constantine found counselor and client race/ethnicity variables contributed significant variance to CCCI-R ratings,  $F(5, 46) = 19.83, p < .001; R^2 = .68$  (adjusted  $R^2 = .65$ ) for African-American and Latino-American trainees. Next, the number of prior multicultural counseling course explained significant variance in CCCI-R ratings,  $R^2$  change = .08,  $F(4, 44)$  change = 15.29,  $p < .001, R^2 = .77$  (adjusted  $R^2 = .73$ ). Specifically, the higher levels of multicultural counseling training, the greater observer rated MCC. Finally, MCI full-scale scores contributed significant variance to CCCI-R ratings,  $R^2$  change = .03,  $F(8, 43)$  change = 6.59,  $p < .05, R^2 = .80$  (adjusted  $R^2 = .76$ ).

Constantine's study was innovative and the first to address observer-rated MCC involving actual counseling situations with clients and trainees. However, findings should be considered in light of some limitations. First, the sample was small and may have "detracted from the power of some analyses to detect statistical significance" (p. 461). For the current study, I plan to recruit the required amount of participants for phenomenological research (Hays & Wood, 2011) and will continue to collect until data saturation occurs (Glesne, 2016). Next, the raters relied solely on one transcribed

interview, which does not provide a full picture of what takes place in session. For the current study, I plan to engage in triangulation, where I will interview counselors from several counseling professions (i.e., CSC, LMFT, LPC); thus, providing me with multiple perspectives of the phenomenon (Glesne, 2016). Further, I will probe participants regarding their experiences with the phenomenon (i.e., life experiences, educational and clinical training experiences, and the post-graduate experiences). Lastly, when completing the MCI, trainees could have engaged in the phenomenon of social desirability (Strike et al., 2004). Therefore, would have been helpful to obtain the client's perspective of the MCC versus the trainees'. For the current study, I will be assessing the SPC of counselors treating children with ASD and their families. However, since there is currently no counseling literature outlining counselor competencies in this area, I believe this preliminary investigation is valuable starting point.

Constantine (2002) investigated MCC and racism attitudes, specifically, White racial identity attitudes of 99 school counselor trainees. The participants were recruited through convenience sampling method in the Northeastern and Midwestern regions of the United States. Predominantly, participants were enrolled in master's-level school counseling courses. Eighty-six women (87%) and 13 men (13%) participated and ranged in age from 21 to 41 years old ( $M = 27.2$ ,  $SD = 4.4$ ). Further, the participants reported 2.68 months ( $SD = 3.65$ ) of counseling experience. Constantine defined White racial identity attitudes and racism as, "White's beliefs in their own individual and cultural superiority over Blacks and other ethnic groups" (p. 164). The author hypothesized that racism and White racial identity attitudes mutually conflict with school counselor trainees' self-perceived MCC.

**Instruments.** Constantine used a wide variety of surveys to measure MCC and White racial identity. The New Racism Scale (NRS) measures Whites' attitudes towards Blacks through a 7-item scale, with higher scores suggesting racist attitudes (scores range from 7 to 25). The Cronbach's alpha of .70 was reported in the normative sample with a mean score of 15.9. For the current study, Constantine computed the Cronbach's alpha of .58. Next, the Multicultural Counseling Knowledge and Awareness Scale (MCKAS) was used. This is a self-report, 32-item scale that evaluates dimensions of MCC (i.e., knowledge and awareness). Coefficient alphas have been reported to be .85. Constantine calculated Cronbach's alphas for knowledge (.85) and awareness (.71) subscales, as well as .83 for the entire scale. Subsequently, Constantine employed the White Racial Identity Attitude Scale (WRIAS), which is a 50-item scale. Constantine reported Cronbach's alphas for the WRIAS including, Contact (.51), Disintegration (.77), Reintegration (.65), Pseudo-Independence (.66), and Autonomy (.72) subscales that assess White racial identity attitudes. Previous studies of the WRIAS coefficient alphas have ranged from .55 to .80. Lastly, Constantine utilized a demographic questionnaire.

**Results.** Constantine conducted a hierarchical multiple regression analysis using the full-scale MCKAS scores (the criterion variable) with the NRS and WRIAS subscales (i.e., race-related attitudinal variables). The author noted the higher numbers of prior multicultural counseling courses were associated with greater levels of self-reported MCC,  $F(1, 97) = 11.34, p < .01; R^2 = .10$ . Further, only the "NRS scores and Disintegration racial identity attitudes contributed unique variance to the MCKAS in that higher NRS scores and higher Disintegration racial identity attitudes were each associated with lower levels of self-reported MCC" (p. 169).

Constantine's study was one of the first to explore self-reported MCC and race-related attitudinal variables; however, limitations must be noted. First, the sample may not be representative of all school counselors-in-training in other regions of the United States. Therefore, generalizing the findings is cautioned. Because the dissertation is a qualitative investigation, findings cannot be generalized, but the themes that emerge can have a meaningful impact (Mason, 2002) on the counseling profession and building counselor competencies working with children with ASD and their families. Second, because the survey was based strictly on self-perceived competencies versus others' perception of trainee's competencies, data may be skewed to represent what the respondents' anticipated rather than actual attitudes were. For the current qualitative inquiry, I plan to investigate the SPC of professional counselors because no data exists on the specific counselor competencies to treat children on the autism spectrum and their families and is a logical place to begin when initially investigating this phenomenon.

Chao (2013) investigated how school counselors' race and ethnicity interacts with MCC and multicultural training. The author tried to recruit a national sample of 1,078 high school counselors, where 259 responded. Those who responded ranged in age from 22 to 63 years old ( $M = 41.34$ ,  $SD = 7.65$ ). Seventy percent of the respondents were women ( $n = 181$ ) and 30% were men ( $n = 78$ ). The racial/ethnic backgrounds were as follows: 179 (69%) White/European Americans, 31 (12%) Blacks, 28 (11%) Latino/Latinas, 13 (5%) Asian Americans, 1 (0.4%) Native American, 5 (2%) biracial, and 2 (0.7%) multiracial (p. 143). Further, participants were asked to indicate their experiences of multicultural training and among the respondents, 9% ( $n = 23$ ) did not

have multicultural training, 77% ( $n = 199$ ) had taken at least one multicultural counseling course, and 14% ( $n = 36$ ) had taken two or more courses (p. 143).

**Instruments.** The Balanced Inventory of Desirable Responding (BIDR) measures the propensity to answer and display behaviors or thoughts that are viewed as socially attractive but not accurate when counselors are self-reporting. The BIDR is a 40-item survey evaluating impression management and self-deception on a 7-point Likert scale. Higher scores imply a greater tendency to respond and present behaviors and thoughts that are viewed as socially desirable. Studies have obtained a coefficient alpha of .85. Chao also used the Multigroup Ethnic Identity Measure (MEIM), which is a 12-item scale designed to measure multiple racial/ethnic identity awareness through a 5-point Likert scale. Higher scores for the MEIM signify greater level of identity awareness and commitment. Among college students, MEIM has a coefficient alpha of .90 and the present study attained a coefficient alpha of .92. Next, the researcher utilized the Color-Blind Racial Attitudes Scales (CoBRAS), which is a 20-item survey that measures color-blind attitudes, with higher scores mirroring higher levels of color-blind positions. Previous studies have reflected coefficient alphas from .86 to .91 of the total score with the present sample coefficient alpha of .88. Lastly, Chao applied the Multicultural Counseling Knowledge and Awareness Scale (MCKAS). MCKAS has two subscales, Multicultural Awareness and Multicultural Knowledge that controls for social desirability, with higher levels indicating MCC in knowledge and awareness.

**Results.** The researcher examined the results to ensure the dependent variable (i.e., MCC) was normally distributed. Once this was established, Chao tested the four hypotheses using hierarchical multiple regression analyses to test the link between

race/ethnicity and MCC. For the first hypothesis, the researcher tested to see if social desirability accounted for the variance of MCC, which it did not. Second, Chao calculated race/ethnicity and multicultural training accounted for 40% of MCC. Chao also noted the two-way interaction significantly predicted MCC ( $\Delta R^2 = .02$ ,  $p < .05$ ). Results indicated the slope with low multicultural training was significantly different from zero ( $B = 0.70$ ,  $SE = 0.28$ ,  $\beta = .25$ ),  $t(258) = 2.50$ ,  $p = .01$ . Thus, White and racial/ethnically diverse school counselors have no significant differences with higher levels of training and MCC. Whereas White school counselors have lower MCC than their counterparts when they have limited training. For hypothesis 2, results “revealed that multicultural training was positively associated with racial/ethnic identity ( $B = 1.67$ ,  $SE = 0.41$ ,  $\beta = .25$ ),  $t(258) = 4.07$ ,  $p < .001$ ” (p. 145). For the last hypothesis, results implied when school counselors have limited multicultural training and elevated levels of color-blind racial attitudes, the connection between race/ethnicity and MCC was not significantly different from zero ( $b = -0.04$ ,  $SE = 0.09$ ,  $p = .66$ ). “These results indicated that school counselors who reported limited multicultural training and high levels of color-blind racial attitudes had the lowest MCC” (146).

Chao’s study reflects counselor educators must attend to racial/ethnic identity and color-blind racial attitudes as significant features for MCC in school counselors. However, there are several limitations to the study. First, because the study was based in school counselors’ self-reported competencies, this may not reveal actual levels of MCC. Even though the present study is based on self-report of counselors’ experiences working with children with ASD, phenomenological research respects the counselors’ voice in describing the phenomenon in their own words (Denzin & Lincoln, 2013). Second,

results cannot be generalized to a specific racial/ethnic group due to the limited number of respondents. For the current study, the goal is not to generalize the findings of participants' responses, but highlight the findings to offer a foundation for future research. Lastly, Chao had a low response rate (i.e., 25%) raising questions about external validity of the results. The current study plans to recruit 15 participants or until data saturation occurs from varying counseling backgrounds to increase trustworthiness of the data (Lincoln & Guba, 1985).

Barden and Greene (2015) investigated the relationship between counseling students' ( $N = 118$ ) level of MCC and multicultural counseling self-efficacy (MCSE) with their demographic information. The participants' characteristics included 86.6% ( $n = 103$ ) master's level students and the other 15 (12.6%) identified as doctoral counselor education students. The bulk of the participants were female (80.7%,  $n = 96$ ) and there were five distinctive racial/ethnic groups: 76 (63.9%) identified as Caucasian/White, 13 (10.9%) as Black/African American, 12 (10.1%) as Latino/Latina, 8 (6.7%) as Asian, 1 (0.8%) as Native American, and 9 (7.6%) as 'other.' The three research questions directing the inquiry were: a) *What is the relationship between counselor education students' levels of MCSE and MCC?* b) *What is the relationship between counselor education students' MCSE, MCC, and demographic data;* and c) *Is there a difference between MCSE and MCC based on grouping by gender, ethnicity, and amount of time in a graduate preparation program?* Participants were recruited through purposive, convenience sampling at differing points in their graduate training.

**Instruments.** The researchers used two instruments to gather data related to MCSE (Multicultural Counseling Self-Efficacy Scale- Racial Diversity Form [MCSE-

RD]) and self-reported MCC (Multicultural Counseling Competence and Training Survey-Revised [MCCTS-R]). The MCSE-RD is a 37-item scale intended to measure counselors' self-perceived ability to counsel racially diverse clients and rate their ability in how confident they feel on a 9-point Likert scale. There were three sub-scales with Cronbach's alphas including Multicultural Intervention (MI; 0.89), Multicultural Assessment (MA; 0.87), and Multicultural Session Management (MSM; 0.95) with total score reliability of 0.98. Next, the authors used the MCCTS-R, which is a 32-item survey that measures counselors' self-perceived MCC on a 4-point Likert scale. Specifically, the MCCTS-R analyzes three factors: Multicultural Terminology (Factor 1), Multicultural Knowledge (Factor 2), and Multicultural Awareness (Factor 3). Previous studies have found satisfactory coefficients for internal consistency ( $\alpha=0.85-0.97$ ).

**Results.** The authors assessed the relationship between counselor education students' levels of MCSE and self-perceived MCC through a multiple linear regression analysis. Full-scale mean scores on the MCCTS-R ( $M = 2.69$ ,  $SD = 0.50$ ) and the three sub-scale mean scores from the MCSE-RD (MI,  $M = 6.52$ ,  $SD = 1.21$ ; MA,  $M = 4.43$ ,  $SD = 2.24$ ; MSM,  $M = 6.51$ ,  $SD = 1.63$ ) predicted variables described the variance 34.6 % ( $R^2 = 0.346$ ) in full-scale mean scores on the MCSE-RD. In sum, as students' MCSE scores increased, their self-reported MCC scores enhanced; thus, competencies and self-efficacy have strong correlations even though they are drastically different from one another. Next, the researchers looked at the relationship between the demographic variables (i.e., gender, ethnicity, and time in graduate school) and MCSE. The authors found the amount of time in graduate school predicted MSM sub-scale of the MCSE-RD,  $R^2 = 0.061$ ,  $F(1, 118) = 7.55$ ,  $p < 0.01$ . This was also supported by the Pearson product-



moment correlation analysis, denoting a statistically significant relationship between time in graduate school and MSM scores ( $r = 0.230, p < 0.05$ ). Further, Barden and Greene looked at the relationship between MCC and the identified demographic variables through a multiple linear regression. The predictor variables explained 13.4 % of the variance in scores on the MCCTS-R,  $R^2 = 0.134, F(1, 114) = 5.725, p < 0.01$ ). Therefore, the statistically significant beta coefficient was time in graduate school.

Barden and Greene's study found that time in graduate training was a predictor of both MCSE and self-reported MCC; however, results should be contemplated in light of limitations. First, the sample is geographically limited, focusing solely on the Southeastern region of the United States. For the current study, I specifically recruited participants from the Northeastern and Southeastern regions of the United States. Therefore, diversifying the sample. Second, the researchers relied on SPC and did not measure social desirability of their participants. For the purposes of the present study, I plan to explore the participants' experiences counseling children with ASD and their families and through this discover their SPC. Because there is no research in the counseling profession identifying specific competencies, categorizing themes will provide a framework for future research.

Johnson and Williams (2015) explored the relationship between White racial identity and color-blind attitudes of counseling students who had at least one month of practicum experience. Researchers recruited a geographically diverse sample of 487 participants (63% response rate) contributed who represented a range of programs (i.e., PsyD, PhD, clinical, counseling, and school psychology). The bulk of participants were enrolled in APA-accredited doctoral programs ( $n = 464, 95.3\%$ ). All participants

identified as White and 400 identified as female (82%) and ranged in age from 21 to 55 years ( $M = 28.3$ ,  $SD = 5.5$ ). The researchers had three hypotheses: (a) *Higher color-blind racial attitudes and lower stages of White racial identity will predict lower multicultural counseling awareness*; (b) *Higher color-blind racial attitudes and lower stages of White racial identity will predict lower multicultural counseling knowledge*; and (c) *Higher color-blind racial attitudes and lower stages of White racial identity will predict lower multicultural counseling skills* (p. 442).

**Instruments.** To measure multicultural training, the researchers developed a measure that assessed self-reported multicultural training experiences (i.e., courses, research projects, workshop attendance). Further, the researchers used the Multicultural Counseling Inventory (MCI), which is a 40-item, 4-point Likert scale measuring behaviors and attitudes related to MCC (i.e., skills, awareness, knowledge, and relationship). Previous studies have reported reliability estimates such as Cronbach's alphas for skills (.77), knowledge (.78), and awareness (.76) subscales. Further, the authors used the White Racial Identity Attitudes Scale (WRIAS), which is a 60-item self-report inventory on a 5-point Likert scale measuring Contact, Disintegration, Reintegration, Pseudo-Independence, Immersion/Emersion, and Autonomy. Previous studies have yielded Cronbach's alphas ranging from .55 (Contact) to .82 (Disintegration); however, the authors noted there has been significant variability in the subscale reliabilities since the publication of the WRIAS. The last instrument the researchers used was the Color-Blind Racial Attitudes Scale (CoBRAS). CoBRAS is a 20-item self-report measure of colorblind racial attitudes (i.e., Unawareness of Racial Privilege, Unawareness of Institutional Discrimination, and Unawareness of Blatant

Racial Issues) that participants rate on a 6-point Likert scale. Higher scores on the scale indicate greater levels of racial blindness, denial, or unawareness. Previous studies calculated good internal consistency reliably and concurrent validity with Cronbach's alphas ranging from .79 (Institutional Discrimination) to .84 (Racial Privilege). Lastly, Johnson and Williams used the Marlowe-Crowne Social Desirability Scale- Short Form (MCSDS-SF), which is a 13-item scale measuring the propensity to positively endorse culturally appropriate behaviors. Higher scores of the MCSDS-SF "indicate a greater tendency to respond in a social desirable manner" (p. 443). The scale development study yielded a .75 Cronbach's alpha reliability estimate.

Johnson and Williams's research further validated the importance of increasing multicultural training in programs and the amount of time in practicum as a significant predictor of knowledge and skills related to MCC. However, limitations must be addressed. The authors' noted previous literature has commented on the utility of the WRIAS because of the inconsistent reliability of some of the subscales. Johnson and Williams rationalized using the measure because individual characteristics are fluid constructs; conversely, this rationale comes from the developer of the measure and therefore, does not preset a valid justification. For the current study, I will not be using quantitative instruments because the study is a phenomenological investigation. However, I did pull from previous research to develop the demographic questionnaire, using 80% of the items that were highlighted in MCC, disability competencies, and ASD competencies studies. In addition, I piloted the interview questions to ensure my research questions were captured; thus, increasing the trustworthiness of my study (Lincoln & Guba, 1985).

Ivers and Villalba (2015) explored the relationship between bilingualism and counseling students' MCC, while controlling for multicultural training and ethnicity. Previous research has found ethnic and linguistic clients underutilize and prematurely terminate counseling services, which increased the need for the study. Thus, the overarching research question was: *Do bilingual counseling students significantly self-rate their multicultural counseling knowledge and awareness higher than monolingual counseling students when controlling for ethnicity and multicultural training?*

The study included 178 participants in a master's-level, CACREP-accredited counseling program in the southwest region of the United States. Out of the 178 participants, 142 identified as female (79.8%), 33 as male (18.5%), one identified as transgendered (0.6%), and two did not categorize their gender (1.1%). The ethnic identity of the participants consisted of 83 Latinas/os (46.6%), 77 Caucasians (43.3%), and 18 African Americans (10.1%). Concerning bilingualism, 71 participants reported they were bilingual (39.9%). The majority of bilingual individuals identified as Latina/o ( $n = 57$ , 80.3%), followed by Caucasian ( $n = 9$ , 12.7%), and African American ( $n = 5$ , 7%). The researchers collected data through the Multicultural Counseling Competence and Training Survey-Revised (MCCTS-R), which has a three-factor structure including Multicultural Knowledge, Multicultural Awareness, and Multicultural Terminology. The researchers removed the terminology subscale because it is not accepted as a key component of MCC because "the conceptual link between bilingualism and knowledge of multicultural terminology is not clear" (p. 423).

The authors analyzed the MCCTS-R Knowledge and Awareness subscales and compared the means and standard deviations, as well as internal consistencies

(Cronbach's alpha) to previous research. Respectfully, the internal consistencies between the Knowledge and Awareness subscales were .95 and .85. To address the research question, a multivariate analysis of covariance (MANCOVA) and a series of covariance (ANCOVA) formulas were used. Results of the MANCOVA exposed a significant main outcome for bilingualism (Wilk's  $\Lambda = .955$ ,  $F(2, 173) = 4.065$ , multivariate  $\eta^2 = .045$ ,  $p < .019$ ). The authors asserted, "this finding indicates that the combination of self-report multicultural knowledge and awareness differed as a function of bilingualism, with bilingual participants self-rating their multicultural knowledge and awareness higher than non-bilingual participants" (p. 424). In addition, ANCOVAs were conducted and the results indicated "bilingual individuals self-rated their multicultural knowledge ( $F(1, 174) = 4.401$ ,  $p = .037$ ,  $\eta^2 = .025$ ) and multicultural awareness ( $F(1, 174) = 7.847$ ,  $p = .006$ ,  $\eta^2 = .043$ ) higher than did monolingual counseling students" (p. 424).

Several limitations exist for this study. First, Ivers and Villalba acknowledged the self-report instrument for the study was a limitation and "is potentially susceptible to intervening variables such as social desirability and ignorance bias" (p. 426). For the present phenomenological inquiry, I will investigate a new area of research that has not been explored before in the counseling literature. Thus, examining the SPC of counselors working with children on the autism spectrum and their families is a practical starting point. Secondly, the researchers admitted to removing participants because they were a "low census ethnic group" (p. 422). Based on the minimal explanation given, the clarification offered is not justifiable. For the current study, I will be transparent with the data analysis and tie direct quotes to validate emerging categories and themes. Lastly, the authors did not measure level of fluency in a second language and relied on self-report of

bilingualism, which may have affected the validity of the study. To ensure the current study is valid, I will engage in several forms of trustworthiness (see Chapter 3 for further details of ‘trustworthiness of study’).

Ivers et al. (2016) examined the association between MCC and mindfulness because research has maintained a theoretical link between the two constructs. They defined MCC as “the effectiveness with which a counselor provides counseling services to clients whose cultural worldviews differ from those of the counselor... wherein MCC was conceptualized in terms of multicultural knowledge, beliefs and attitudes (awareness), and skills” (p. 72). The authors also defined mindfulness as a “unique form of attention in which an individual brings complete focus to present-moment experiences in an accepting and judgment-free manner” (p. 73). The following research questions directed the study: *Does mindfulness related to multicultural counseling knowledge and awareness? If so, what aspects of mindfulness are associated with multicultural knowledge and awareness and do these mindfulness components related to multicultural knowledge awareness above and beyond that of race/ethnicity, multicultural course completion and empathy?*

The researchers collected data from four instruments, which included: (a) the Five Facet Mindfulness Questionnaire (FFEQ) a 39-item self-report assessment of mindfulness; (b) the Toronto Empathy Questionnaire (TEQ) a 16-item self-report assessment measuring emotional empathy; (c) the Death Concern Scale (DCS); and (d) the Multicultural Competence Training Survey-Revised (MCCTS-R) a 32-item self-report instrument that assess counselors’ competence regarding multicultural knowledge, awareness, and terminology. After a post hoc power analysis with an alpha level set at .05

and effect size set at .15, the sample size was secured. The participants included 199 master's-level students enrolled in CACREP-accredited program in a designated Hispanic-serving institution in the southwestern United States. The sample included 78.9% women, 19.1% men, 0.5% transgender persons, and three did not identify their gender. The racial and ethnic makeup of participants were 42.2% Latina/o, 39.2% Caucasian, 9.0% African American, 3.0% Asian or Pacific Islander, and 3.0% biethnic or multiethnic, 2.0% of participants selected "other," and 1.5% did not identify their race or ethnicity.

**Results.** The researchers analyzed the results by calculating descriptive statistics for multicultural awareness and knowledge, race/ethnicity, and multicultural course completion. The results indicated a significant relationship between mindfulness and multicultural awareness when the researchers computed linear regressions on the constructs. In addition, the researchers conducted a post hoc analysis to examine which factors of mindfulness were correlated with multicultural awareness and knowledge. Based on two multiple regressions of the mindfulness factors from the FFMQ, "only mindfulness non-reactivity to inner experience was significantly associated with self-perceived multicultural awareness,  $t(197) = 2.19, p = .030$ , and only mindfulness describing was significantly related to multicultural knowledge,  $t(197) = 2.64, p = .009$ " (p. 76). Based on the results from the study, the data analysis revealed a relationship between overall mindfulness and MCC and partially supported the first two hypotheses. Additionally, completion of the multicultural course increased participant's knowledge, but did not indicate an association between multicultural awareness.

While findings of Ivers et al. study are clearly valuable because it is the first to empirically validate the relationship between MCC and mindfulness, limitations must be noted. First, the researchers recruited participants using convenience sampling; thus, one may caution from generalizing results. The current study is a qualitative investigation and does not claim to be generalizable; therefore, I hope to engage participants through purposeful and snowball sampling methods (Glesne, 2016). Secondly, the authors recognized the self-report instruments they utilized were “hypothesized link constructs” and are commonly used in MCC literature. For the present qualitative inquiry, I will be exploring the SPC of counselors working with ASD because there is currently no literature available on this clinical population and how it relates to MCC. Thus, investigating SPC treating children on the autism spectrum and their families is an important preliminary investigation for the profession. Finally, it was not clear why the researchers did not provide descriptive statistics or a description of the DTS instrument, leaving the reader to ponder what exactly the instrument was used for in the study.

### **Disability Competence**

Kemp and Mallinckrodt (1996) investigated participants’ case conceptualization, treatment planning, and evaluation of problem severity of a client who appears nondisabled or as disabled (i.e., using a wheelchair). Further, the researchers examined the influence of previous training in disability issues on the case conceptualization and treatment planning on the client. Two 30-minute analogues were presented to participants, where the content was identical aside from presence of disability.



**Measures.** Kemp and Mallinckrodt used the Attitudes toward Disabled Persons Scale- Form A (ATDP-A), which consists of 30 statements that measure attitudes towards those with a disability. The second scale that was used was a researcher-developed tool entitled Anticipated Course of Treatment Questionnaire (ACTQ), which measures case conceptualization of clients with disabilities, specifically, the presenting issue of the client for the videotape analogues. The researchers' utilized a panel of experts to develop the 24 treatment themes and referenced published sources. The last measure was the Marlowe-Crowne Social Desirability Scale (MCSD), which is a 33-item inventory that assesses one's tendency to avoid disapproval of those who might evaluate responses.

**Participants and procedure.** From the 237 practicing therapists and students solicited for the study, 47 participated and were from varying helping professions (i.e., counseling psychologist, LPCs). Participants were randomly assigned to one of the two analogues with a sealed packet of the self-report measures.

**Results.** Evidence suggested social desirability bias did not significantly affect the attitudes towards the disabled client in the sample. Of the 47 participants, a little less than half ( $N = 23$ ) specified they had not obtained special training of any type regarding persons with disabilities. The researchers found even a small amount of training on issues with persons with disabilities are associated with less bias in case conceptualization and treatment planning. For example, participants with no special training gave career development a significantly higher priority than relationship issues ( $M = 2.15$ ,  $SD = 0.69$ ).

Limitations must be listed regarding Kemp and Mallinckrodt's study. First, the authors developed the ACTQ and did not offer the psychometric properties, in addition to the researchers not providing the validity and reliability of the measure. Second, the sample size was small and cannot be generalized. Finally, the results section was confusing and the authors did not explain the results in a statistically sound manner. Therefore, for the current study, I engaged in piloting the interview questions to ensure the questions honored the participants' voice, as well as coincided with the research questions. Next, the study is a qualitative inquiry; thus, cannot be generalized, but I will engage in reflective journaling to ensure the voice of the participants is showcased (Denzin & Lincoln, 2013). Lastly, I will enhance my findings through several methods of trustworthiness, such as a coding map, where iterations and analysis are presented making the "aspects of the analysis process open to public inspection" (Anfara, Brown, & Mangione, 2002 p. 33)

Gourdine and Sanders (2002) study was intended to raise the profession's responsibility to teach disability content in schools of social work, as well as embrace an interdisciplinary approach. The theoretical framework the researchers used was the *ecosystems framework* and the *lifespan perspective*. Both are holistic in nature and consider the biopsychosocial experiences in order to understand human functioning of those with a disability. The researchers investigated six research questions related to how disability content is covered in masters of social work (MSW) programs: *Does the infused content prepare students to work with persons with disabilities, is advocacy included, and do MSW programs use interdisciplinary models to teach disability content?*

**Results.** The authors used the Social Work Access Network (SWAN) to locate schools with MSW programs in the United States. Of the 102 schools listed on SWAN, the authors investigated 83 programs with published course descriptions or catalogues on the website. Twelve (16%) specifically listed courses that covered disability-related content. For the purposes of the study, a content analysis was conducted to answer the research questions using the sample of 12 schools. Over fifty percent of the MSW programs included disability content. Specifically, course descriptions outlined the infusion of: (a) Deaf content, (b) basic overview of disability, (c) specialized content, (d) explicitly focused on children with disabilities, (e) policy, (f) field instruction, (g) micro and macro method interventions, and (h) human behavior.

Gourdine and Sanders provided a thorough historical outline of the infusion of disability content in schools of social work. Conversely, there were numerous limitations related to the study. For example, there are limitations to this data collection process (i.e., an Internet search to identify a sample for the study). First, schools may have specific disability courses, but may not publish them on the school's website. Further, the course descriptions on the SWAN website may not reflect the content covered in a course. Therefore, the study has limited generalizability. For the purposes of the current study, my intent is not to generalize my findings, but use the data to draw implications for the counseling profession and provide a competencies framework to be utilized across counselor education, supervision, and counseling practice.

Strike et al. (2004) investigated mental health professionals' SPC when working with clients with disabilities. They defined three elements of disability competence as: "(a) self-awareness/beliefs/attitudes towards disability, (b) perceived knowledge of

disability and disability-related issues, and (c) perceived skills/behaviors in working with clients with disabilities” (p. 322). They tied disability competence to Sue et al.’s (1992) MCC model. The four research questions they investigated were: (a) *Do mental health professionals with different levels of prior exposure to disability report different levels of competence when working with clients with disabilities?*; (b) *Does mental health professionals’ self-reported level of competence differ among self-awareness, perceived knowledge, and perceived skills?*; (c) *Do mental health professionals report the highest level of competence in the area of self-awareness?*; and (d) *Are the results accounted for by mental health professionals responding in an overly socially desirable manner?*

**Participants.** Participants were recruited through two universities at APA-accredited doctoral programs in counseling, four disability service offices, and four university counseling centers. The mental health professions who participated included psychiatrists, psychologists, social workers, career counselors, disability specialists, and other mental health professionals. The researchers reported 108 surveys were returned (63% response rate), where 75 women (69%) and 33 men (31%) participated. Years of experience counseling the general population ranged from 1 to 36 ( $M = 12$ ,  $SD = 9$ ) and the group with more disability-related experience had an average of 16 ( $SD = 9$ ). All of participants reported they had some type of experience related to disability (i.e., personal experience, training, work experience, etc.). To establish the ‘experienced group’ ( $n = 33$ ) versus the ‘not experienced group’ ( $n = 77$ ), the researchers consulted with expert reviewers to determine group membership.

**Measures.** The Counseling Clients with Disabilities Survey (CCDS) measures mental health professionals’ disability competence based on self-awareness, perceived

knowledge, and perceived skills. The CCDS is closely tied to MCC, counseling, and disability literature. The CCDS consists of 67 items, and seven demographic questions at the end. The CCDS comprises three scales, which include: (a) self-awareness, (b) perceived knowledge, and (c) perceived skills. Strike et al. reported an internal consistency of .94 for the total scale. Internal consistencies for each scale (self-awareness [.67], perceived knowledge [.87], and perceived skills [.90]) demonstrated acceptable reliability, although the self-awareness scale is slightly below the cutoff of .70. Strike et al. demonstrated correlations between awareness and knowledge scales (.72), awareness and skills scales (.69), and knowledge and skills scales (.81). The CCDS was normed with 108 mental health professionals from APA approved doctoral programs in counseling, university counseling centers, and disability service offices.

Another measure that was used was, the Paulhus Deception Scales (PDS) to measure social desirability and is helpful for self-reported MCC. The PDS included “two measures of socially desirable responding, Impression Management (IM) and Self-Deceptive Enhancement (SDE). Accordingly, IM taps inflated self-descriptions given to an audience, and SDE taps an unconscious inflated self-description. Cronbach’s coefficient alpha for the two scales ranged from .70 to .84. When measuring the convergent validity, the correlations between IM and SDE have ranged from .20 to .32, which suggests the scales are relatively independent.

**Results.** The experienced group scored significantly higher than the not experienced group on all three competencies,  $F(1, 106) = 42.687, p < .0001$ . There was a large effect size, 1.26, between self-awareness, perceived knowledge, and perceived skills from the experienced group and the not experienced group,  $F(2, 105) = 17.428, p <$

.0001. The researchers followed up with a MANOVA between the two groups and found differences between self-awareness and perceived knowledge,  $F(1, 106) = 28.920, p < .0001$ , and between self-awareness and perceived skills,  $F(1, 106) = 24.900, p < .0001$ . Overall, the experienced group scored higher in self-reported disability competence than the not experienced group. Lastly, the researchers measured social desirability between the two groups and found they fell within normal range (PDS,  $T$  scores of 51; IM,  $T$  scores from 51 to 52; SDE,  $T$  scores from 48 to 49).

Strike et al.'s innovative study was the first to address specific disability competencies and measure the SPC of mental health professionals. Even though this was a groundbreaking study, limitations must be addressed. First, the participants' completed a self-reported measure and may be distorted by the individuals' perceptions. Second, the authors provided limited reliability and validity data for the CCDS. Lastly, the current study can only be generalized to the university-based counseling centers and disability service offices; therefore, future research is needed to expand the sample. My dissertation will address all three of these limitations. Since this is the first study addressing the counseling competencies needed to treat children on the autism spectrum and their families, obtaining counselors' SPC is a preliminary step. Future research can address client-feedback and supervisors' perception of counselors' effectiveness treating children with ASD and their families. Next, I will be engaging in several forms of trustworthiness to enhance the validity of my findings. For example, I will member-check with participants to ensure their voice is documented appropriately (Denzin & Lincoln, 2013). Finally, because I am engaging in a qualitative inquiry, research cannot be generalized; however, explanations and/or arguments stemming from the research are generalizable in

some way (Mason, 2002).

Weiss et al. (2010) investigated Canadian psychology graduate student training on developmental disabilities (DD) due to the increased involvement of psychologists (i.e., diagnosing and using standardized instruments) with this population. The purpose of the study was to understand the perspectives of graduate students in psychology programs based on didactic and clinical training in DD. The researchers hypothesized the *majority of participants would not rate their level of DD training as sufficient*. Additionally, they hypothesized *the degree of DD training would be related to level in graduate school*.

The researchers recruited participants from the Canadian Psychological Association (CPA) accredited programs in Clinical Psychology, Clinical Neuropsychology and Counseling Psychology. The analysis was limited to 29 programs, where 303 participants responded to the online survey. The researchers categorized graduate school experiences by “beginner” (master’s program), “intermediate” (PhD/PsyD year one to year two), and “advanced” (PhD/PsyD year three or above). Next, the authors adapted a previous survey used with medical students’ training in DD that focused on graduate school training.

**Results.** Respondents were categorized as ‘beginner’ (27%), ‘intermediate’ (35%), and ‘advanced’ (39%) with 69% consisting of PhD-level students and 23% as masters-level students. Most of the graduate students recognized training in DD as “somewhat important” (55.6%) and 85% agreed that training in DD would advance their aptitude to provide psychological services to persons with DD. Furthermore, 70% indicated they did not take a fixed or elective course in DD as part of their graduate training. When respondents “were asked to rate how well they felt they were educated to

work with persons with DD, 40% rated their overall education as “sufficient but need more” and 54.5% rated their education as “poor” (p. 180). There was no relationship between level of graduate school and overall education rating,  $X^2 (2, 297) = 2.50, p = .29$ . Through a chi-square analysis, a positive relationship between the level of graduate school and training in the diagnosis of DD was established,  $X^2 (6, 297) = 26.56, p < .001$ . Further, a greater proportion of students in the “youth focused” group reported a “sufficient” rating (72%) compared to those in “adult focused” group (25%),  $X^2 (2, 297) = 30.42, p < .001$ . Lastly, the researchers inquired what types of additional training respondents would like to see incorporated in their schooling. “Over 80% of students would like to have more clinical contact with people with DD, more current content on DD in classes, have guest lectures by specialists in DD, and have more curriculum dedicated to DD content.” (p. 181).

Weiss et al. highlighted how psychologists must have training in the assessment and diagnosis, management of behavior, and understanding of mental health concerns for those with DD. However, limitations must be highlighted. First, because this was an online survey, the researchers cannot rule out the possibility that those who responded had an interest in the topic of DD and may not be representative of all graduate students in psychology programs. Second, the researchers acknowledged they modified a current survey, but did not address what modifications they made to the instrument and did not provide the validity and reliability of the measure. For the purposes of the present study, I intend to seek out those who have a history of treating children and families diagnosed with ASD to highlight the phenomenon of building competencies with this population. In addition, I plan to engage in several elements of trustworthiness to validate my findings



(Lincoln & Guba, 1985).

Thomas et al. (2011) investigated diversity perceptions of service professionals (i.e., counselors, rehabilitation providers, and teachers) and compared the preparation and perceptions of the three professions. The authors defined *disability* as a societal construct to a non-normative existence and have been socially constructed “by language, sociocultural practices, by institutions, and by politics” (p. 182). Participants in the study were graduate students ( $N = 172$ ) enrolled in rehabilitation (20%), counseling (29%), general (31%) and special education (20%) courses. A majority of the sample had a bachelor’s degree (67%,  $n = 130$ ), 30% ( $n = 51$ ) had a master’s degree, and 3% ( $n = 5$ ) had an education specialist degree. In terms of gender demographics, 21% ( $n = 34$ ) identified as male, 79% ( $n = 130$ ) categorized as female, and eight participants did not classify gender.

**Instrument.** The researchers used the Disability Perception Survey (DPS), where demographic information and responses to two separate one-paragraph hypothetical scenarios regarding persons with disabilities was requested. The first scenario focused on physical disabilities and the second outlined mental health concerns. Following the scenarios, 17 adjectives that were rated on a 5-point Likert scale were used regarding feelings towards the scenarios. Higher scores signified more perceptions that are positive. Previous studies have indicated sufficient internal validity constructs for the DPS. Additionally, there was extremely strong test-retest consistency based on the reported reliability coefficient for the overall instrument of  $r = .96$ .

**Results.** The data was scrutinized through a MANOVA and descriptive data analysis. Results of the three service professions and the dependent measures (i.e., overall

perception of disabilities, overall perception of physical disabilities, overall perception of mental disabilities, anxiety/calmness related to mental disabilities, anxiety/calmness related to physical disabilities, hostility/receptivity related to mental disabilities, and hostility/receptivity related to physical disabilities) indicated a significant between-subjects main effect, Wilks'  $\lambda = 0.81$ ,  $F(12, 322) = 2.92$ ,  $p < .01$ , partial  $\eta^2 = .10$ . For overall perception of disabilities (physical and mental), significant difference were found between the three groups of service professionals,  $F(2, 169) = 4.81$ ,  $p < .01$ , with special education/rehabilitation providers reporting the most positive overall perceptions ( $M = 3.70$ ) followed by counselors ( $M = 3.53$ ), then general education teachers ( $M = 3.41$ ). For the overall perception of physical and mental disabilities, there was not a statistically significant difference between the three groups.

Even though Thomas et al.'s study emphasized the importance of understanding professionals' perceptions and the preparation of human service providers, limitations must be highlighted. First, the researchers relied solely on self-report from students in the four programs and did not account for social desirability and thus, may not reflect participants' true perceptions (Strike et al., 2004). Perceptions can be affected by previous exposure to persons with disabilities, which the researchers did not account for. Thus, for the current study, I plan to ask participants' their previous experiences with children and families with ASD. Further, I will be investigating the SPC of counselors treating children on the autism spectrum. However, the profession must understand counselors' experiences to identify a framework to guide future research regarding supervisors and/or clients' perceptions of competencies.

### **Autism Spectrum Disorder Competence**

Cascella and Colella (2004) surveyed 82 school-based speech and language pathologists (SLPs) regarding their self-reported pre-professional academic and clinical training in ASD and subjective knowledge about characteristics of treatments for ASD. The authors compiled a list of 990 SLPs and randomly sampled 166 (50.3% response rate). The scale was researcher-designed and consisted of demographic questions, general ASD knowledge statements, and ASD communication disorder knowledge statements. All content was pulled from a variety of professional ASD resources, increasing item validity. To increase content validity, five SLPs offered to review and provide opinions on items and suggestions were incorporated. The rating scale had five sections, which included: Section 1 (Education), Section 2 (Academic Preparation), Section 3 (Clinical Preparation), Section 4 (Work Experience), and Section 5 (ASD Knowledge). The survey was then mailed and asked participants to rate their knowledge and apply it to preschool and elementary school children with ASD.

**Results.** The majority (77.8%) of participants had at least four years of experience working with children with ASD in a school setting and about one third had over ten years of experience. For the participants' pre-professional training in ASD, all held a master's degree as an SLP. The majority of respondents' (69.2%) reported none to very little preparation in their undergraduate and graduate education. Further, about half (50.6%) identified taking one academic course that provided information on ASD. In addition, participants' reported very little clinical preparation (75.3%) and about half (51.2%) had "no hands-on experience with ASD as a student" (p. 247). Cascella and Colella also compared pre-professional ASD training by decade (i.e., 1970s to 1990s) and found only a minor increase of academic training of ASD from 1991 to 2000 and "no

changes in the participants' clinical preparation by decade graduated" (p. 247). For the participants' professional training and current experience with ASD, 81.7% attended continuing education explicitly on ASD, where training was acquired through work settings (54.8%) and on their own (89.1%). Participants' self-perceived experience among children with ASD was: Minimally experienced (21.3%), somewhat experienced (31.2%), experienced (35.0%), and very experienced (12.5%). For the participants' ASD general knowledge, the researchers found SLPs reported the highest levels of knowledge regarding behavioral characteristics of ASD and the lowest levels regarding differential diagnosis and educational assessment methods. When the authors observed knowledge of communication disorders associated with ASD, SLPs reported knowing the most about social skills interventions and the least about naturalistic interventions, incidental teaching, and applied behavioral analysis.

Cascella and Colella study was one of the first to examine SLPs self-perceived knowledge and treatment of ASD, as well as academic and clinical training in ASD; however, results should be interpreted with caution. First, the survey was voluntary and those who completed the survey may have personal and/or professional interest in ASD. For the current study, I want participants to self-identify as counselors who work with children and families with ASD so data can potentially lead to counseling competencies in the field. Second, the authors did not verify the respondents' competence in the areas of ASD. This may also be a limitation of the current study; though, this will be the first study (quantitatively and qualitatively) to investigate counselors' clinical work with ASD and how these competencies, if at all, are built overtime. Lastly, the sample was regionally bound and participants were only recruited from Connecticut. My study will

recruit participants from the Northeast and Southeast region of the United States to diversify sample and will be interviewing professional counselors from several specialty areas (i.e., CSC, LPC, and LMFT).

Schwartz and Drager (2008) extended the work of Cascella and Colella (2004) and surveyed 67 SLPs to provide a more “national view of SLPs’ preprofessional training and knowledge of ASD” (p. 67). Furthermore, the authors explored the competency of SLPs working with this population and sought to answer the following questions: (a) *What knowledge do school-based SLPs have concerning autism?* (b) *What educational and clinical training do SLPs receive in autism?* and (c) *Do SLPs have confidence in their ability to provide services to children with autism and their families based on the training they have received?*

The researchers developed a survey that consisted of four parts, which include: Part I, background information; Part II, clinical and educational training; Part III, characteristics of autism; and Part IV, competency in autism. The survey was sent through the American Speech-Language-Hearing Association (ASHA) listserv, as well as through mailing addresses of 1,000 ASHA members. Potential participants had to work in a school setting and work with children between the ages of birth to 17 years old.

**Results.** Across 33 different states, 67 participants responded to the survey with a majority identifying as having their master’s degree (94%,  $n = 63$ ) with the remaining four participants holding a doctorate. Participants had earned highest degree between the years 1970 to 2004 and the number of years in a school setting was between 1 to 16 and more. As it pertains to the respondents’ clinical and educational training, all 67 reported they had zero classes during their undergraduate degree that addressed information

regarding ASD. However, a majority (56.7%,  $n = 38$ ) of the participants reported having one or two courses that addressed ASD in the curriculum. Furthermore, over half (55.2%,  $n = 37$ ) of the participants reported they did not have contact with persons with ASD during their clinical training. With regard to participants' responses to the characteristics of autism, the respondents' "appeared to have more accurate knowledge regarding characteristics of children with autism than they did regarding the diagnostic criteria" (p. 69). In addition, participants' responses implied that SLPs opposed many myths that presently exist regarding autism; however, there were several questions where the mean response fell about the average response. For example, "I feel that children with autism have special talents and abilities" (average score of 2.58). Lastly, the researchers measured participants' competency with autism. The survey revealed 25.3% ( $n = 17$ ) or participants "did not feel competent in their ability to determine goals for children with autism, and (32.8% ( $n = 22$ ) were not comfortable counseling parents of children with autism" (p. 72). Additionally, participants indicated they would have benefited from further training and coursework in school as it relates to ASD (91.0%,  $n = 61$ ).

Several limitations of the study exist. The sample size of the study is a concern and may not reveal the perception of the profession as whole. For the current study, I plan to recruit the suggested amount of participants for phenomenological research (Hays & Wood, 2011). Further, I recognize that qualitative research does not attend to generalizability, but instead, captures the meaning participants' make of the phenomenon (Glesne, 2016). Second, since the survey was voluntary, potential participants may have opted not to respond to the inquiry and may influence the results. I plan to specifically recruit participants who identify as counselors and currently work with ASD to endorse

the creation of ASD counseling competencies. Lastly, the researchers developed their own instrument for the study and did not provide the reliability and validity of the measure. For the current study, I plan to engage in procedures that validate my findings through the elements of trustworthiness (Lincoln & Guba, 1985).

Plumb and Plexico (2013) investigated the training experiences (i.e., continuing education received, supports provided by school districts, role of the participant in the screening and diagnosis of ASD, types of interventions used, and familiarity of current research) of SLPs working with children with ASD. Respondents were recruited through ASHA and listed their current employment setting as pre-elementary, elementary, or secondary school. A total of 401 participants (return rate 6.4%) completed the survey where 98.8% held a master's degree ( $n = 396$ ) and 1.2% held doctoral degrees ( $n = 5$ ). The sample was pulled from 39 different states and a range of 16 years of less experience as an SLP. Further, 39 respondents (9.7%) indicated they had received their highest degree between 2006, while 362 (90.3%) specified before 2006. The researchers developed their 46-item survey where they investigated the following areas: (a) background, (b) academic and clinical preparation, (c) service delivery (i.e., intervention and assessment), (d) evidence-based practice, (e) confidence in service provision, and (f) support provided by school districts (p. 92).

**Results.** For participants' educational and clinical training, the majority (76.8%,  $n = 308$ ) reported they did not take a course dedicated specifically to ASD during their graduate training, whereas 16.2% ( $n = 65$ ) had taken one course, and 7% ( $n = 28$ ) had taken two or more courses. Further, a chi-square analysis was conducted to evaluate whether graduate courses were the primary topic of ASD completed by recent graduates

(two levels, recent and pre-2006). Participants' year of graduation and number of courses taken were found to be significantly related, Pearson  $X^2(2, N = 401) = 8.10, p = .017$ , Spearman's rho ( $\rho$ ) =  $-.131$  ( $p = .92$ ). Parawise comparisons were conducted across all comparisons and the Holm's sequential Bonferroni method was used to control for Type I error. A majority (38.9%,  $n = 135$ ) reported ASD was discussed for a week, whereas 35.7% ( $n = 124$ ) reported it was discussed in one class and a significant amount of respondents (83,  $n = 288$ ) indicated they would have benefited from additional coursework in the areas of ASD.

For participants' caseload role and responsibilities, most respondents (98.8%,  $n = 396$ ) indicated they had children with ASD on their caseload. Additionally, the responses varied to the extent of collaboration with other school personnel. For example, the majority of respondents' (31.2%) reported collaborating weekly. For participants' intervention and assessment methods, a large portion (78.3%,  $n = 310$ ) identified they had at least one child where they utilized a combination of therapy approaches. When queried, respondents' indicated they played a role in screening (65.4%,  $n = 224$ ) and diagnosing (63.1,  $n = 250$ ) students with ASD. In addition, confidence levels were investigated as it relates to the respondents' confidence in areas of service delivery and expressed confidence in three areas: (a) roles and responsibilities (>88%), (b) knowledge and skills related to assessment (>86%), and (c) knowledge and skills related to intervention (>85%). Lastly, participants' addressed school district support, where a large proportion (81.8%,  $n = 328$ ) reported they attended continuing education (CE) sessions supported by the school districts, while 84.55 ( $N = 339$ ) indicated they independently attended CE sessions.



Plumb and Plexico's study exploring the experiences, training and confidence treating ASD provided a thorough perspective of the preparedness of SLPs; however, limitations must be noted. First, the response rate was low when the researchers emailed the survey. For the current phenomenological study, I will recruit 15 participants or when data saturation occurs (Glesne, 2016). Second, generalization of the results is limited because those who completed the survey may have personal and/or professional interest in ASD. For the current study, I will recruit counselors who treat children and families with ASD. Lastly, the survey was researcher-developed, where Plumb and Plexico did not provide the validity and reliability of the measure. For the current qualitative inquiry, validity will be established through several forms of trustworthiness (Lincoln & Guba, 1985).

Burnett (2014) explored SLP graduate students' preparedness to work with children with ASD and surveyed participants' "current levels of knowledge, information about expectations for the preparation of graduate students, and an overview of the role of the SLP" (p. 2). Participants were recruited through the ASHA database and emailed the survey. Of the 2,765 SLPs who received the survey, there were 551 participants (19.9% return rate). The survey was adapted from previous research (see Cascella & Colella, 2004; Schwartz & Drager, 2008) and was validated for both item and content validity. Respondents answered 58 question divided into the following sections: (a) demographic and background information (i.e., training and experience); (b) self-perceived knowledge of ASD; (c) objective knowledge of ASD; (d) perceived challenges of working with ASD; (e) expectations for graduate coursework; and (f) skill expectations for clinical fellow. A student outcome measure was administered to graduate

students who completed a course in ASD ( $N = 25$ ) to obtain levels of knowledge and previous exposure to ASD. The pre and post-test was 40 questions.

**Results.** Based on the respondents' academic and clinical training, the majority of participants (42.7%,  $M = 2.36$  and  $2.42$ ) believed they were not ready to begin working with persons with ASD. Burnett utilized true/false questions to assess participants' general knowledge of ASD. Several questions had lower percentages in proportions for answering correctly. For example, over half (51.8%) of the participants answered the question, "the average age of diagnosis for ASD is between 4 ½ and 5 ½ years of age" wrong. Furthermore, a majority of the participants (86.9%) promoted a standalone course for ASD using a Likert scale and such a course should be required ( $M = 4.33$ ). For the student outcome questionnaire, the responses indicated an increase in knowledge "for the objective questions pertaining to characteristics of ASD (78% to 86%), prevalence & causes of ASD (76% to 85%), and diagnosis & intervention in ASD (83% to 89%)" (p. 3-4).

Burnett addressed limitations from previous studies to validate her current study; however, results should be interpreted with caution. First, the study did not explain gender differences between male and female responses. For the current study, I plan to recruit both male and female participants to diversify the sample. In addition, I plan to recruit participants from various counseling disciplines. Second, the author did not provide a solid rationale for why she investigated student-learning outcomes and how it relates to the current study. For my study, I will engage in transparency so findings are clear to all readers (Anfara et al., 2002). Lastly, the author mostly utilized descriptive statistics to explain her sample and current trends in the SLP field as it pertains to ASD.

Therefore, my study's methodology will be dynamic to increase the trustworthiness of the study (Lincoln & Guba, 1985).

Dinecola and Lemieux (2015) examined social work students' actual experiences, self-efficacy and interest in working with persons with ASD due the previous studies in the field reporting low interest in working with persons with a developmental disability. The authors defined self-efficacy as one's knowledge, attitudes, and training. In addition, Dinecola and Lemieux's study is grounded in social cognitive career theory using a multivariate approach. Therefore, the research questions were as follows: (a) *What are the interrelationships among interest, knowledge, attitudes, contact, training, and self-efficacy?* and (b) *Among correlates, what combination of predictors best explains the variance in social work students' self-efficacy in working with persons with ASD?* (p. 29).

Out of the 200 students enrolled in an MSW program in the Southeast region of the United States, ninety-seven graduate social work students volunteered to take the survey; thus, the researchers engaged in availability sampling method. Participants were encouraged to complete surveys outside of class and return surveys to a designated bin in the common area and were collected over the span of four weeks. The sample was primarily Caucasian (75.3%) and female (86.6%). Participants' ages ranged from 22 to 52 years old ( $M = 26.4$ ,  $SD = 1.47$ ). Overall, the sample included 39 (40.6%) foundation-year students and 57 (59.4%) advanced-year students. The researcher-designed survey was pre-tested by a comparable sample of MSW students. Feedback was provided and the final questionnaire consisted of 65 items that measured "participants' knowledge about ASDs, self-efficacy in working with persons with ASDs, attitudes toward working

with individuals with ASDs, interest in working with individuals with ASDs, formal training in ASDs, and contact with persons with ASDs” (p. 30).

**Data Analysis.** For the exploratory study, univariate statistics were used to summarize data. In addition, prior to utilizing multivariate analyses, the researchers used a correlation matrix to compute interrelationships among relevant variables from the data. The strongest relationship (i.e., attitudes and interest [ $r = .55, p < .01$ ]) with the correlations matrix was run between pairs of variables was established. All of the other interconnections among predictor variables were weak, ranging from .01 to .24. Furthermore, employing a forward step method was used in the ordinary least squares regression to assess the extent variables (i.e., knowledge, interest, contact, and workshops) best explained the variance of participants’ self-efficacy in working with persons with ASD.

**Results.** Levels of knowledge concerning ASD ranged from 0 to 22 ( $M = 14.4, SD = 4.73$ ), indicating relatively low levels of knowledge. For example, when participants were asked about treatment, fewer than 20% knew injection of secretin was not a valid medical treatment for ASD. The authors measured the self-efficacy scales using the Cronbach’s alpha (.89), indicating good internal consistency. The self-efficacy scale indicated moderate levels of confidence when working with persons with ASD ( $M = 34.5, SD = 16.39$ ). For the attitudes scale, the Cronbach’s alpha was .72, indicating moderate internal consistency. Total scale scores ranged from 34 to 64 ( $M = 52.4, SD = 5.81$ ), indicating positive attitudes towards working with persons with ASD. For example, participants’ believed working with individuals with ASD would develop one’s skill as a social worker ( $M = 5.5, SD = 0.68$ ).

In regards to respondents' formal training and contact with persons with ASD, participants' indicated they received most information about ASD through one method of instruction ( $M = 2.2$ ,  $SD = 1.52$ ). Additionally, a significant portion ( $n = 13$ , 13.4%) of the respondents' reported receiving no information about ASD through their graduate-level course work. Furthermore, the majority of participants ( $n = 89$ , 91.8%) reported never attending a workshop on ASD. Lastly, Dinecola and Lemieux investigated participants' professional and personal interactions with persons with ASD. Findings indicated participants most often interacted with individuals with ASD in one type of professional setting ( $M = 1.4$ ,  $SD = 1.00$ ). Well over half of the respondents ( $n = 59$ , 60.8%) identified interacting with persons with ASD in their personal lives. Further, one third or participants ( $n = 36$ , 37.1%) interacted with individuals in a volunteer setting, paid work setting (22.7%), or field placement (15.5%).

Lastly, correlates of self-efficacy and multivariate analyses were computed using the .01 threshold of significance to determine predictors of self-efficacy when participants worked with individuals with ASD. All of the following were significant at the  $p < .01$  for self-efficacy with a moderate and positive association with knowledge ( $r = .30$ ), methods of instruction ( $r = .34$ ) and contact ( $r = .22$ ). Based on the results of bivariate analyses, there were two predictors (i.e., knowledge and contact) that "explained a significant portion of the variance in students' self-efficacy  $R^2 = .180$ ,  $F(2, 86) = 9.431$ ,  $p < .001$ . This model accounted for 18% of the variance of self-efficacy" (p. 34).

Dinecola and Lemieux study was the first to investigate interrelationships among graduate social work students' knowledge, self-efficacy attitudes, interest, formal

training, and contact regarding practice with individuals with ASD. However, limitations must be noted. First, the scale used was a researcher-developed scale and did not yield validity and reliability data; thus, further psychometric testing is warranted. Furthermore, since the survey was based on social work students' self-perceived knowledge, interest, and attitudes regarding persons with ASD, examining social desirability bias is necessary (Strike et al., 2004). Lastly, the researchers sample was drawn from one graduate social work program in the Southeast region of the United States. Therefore, findings must be generalized with caution. For the current study, I developed interview guide (see Appendix D), which was validated by a pilot interview. Second, the counseling profession has not identified specific counseling competencies needed to treat children with ASD; hence, this preliminary investigation must start with investigating professional counselors' experiences working with children with ASD and their families and future studies should examine supervisor and client feedback. Lastly, I will be interviewing professional counselors from several fields (i.e., CSC, LPC, LMFT), as well as will interview participants in the Northeast and Southeast region of the United States to diversify the sample.

### **Summary of quantitative findings**

In sum, the comprehensive quantitative studies present useful findings on how counselors develop counseling competencies, MCC, disability competencies, and ASD competencies. Across all studies investigating MCC, themes yielded similarities including the benefit of *integrating multicultural counseling curriculum* in counseling programs to build students' MCC in awareness, knowledge and skills. Further, self-perceived MCC, MCSE (Barden & Greene, 2015), and mindfulness (Ivers et al., 2016)

were correlated with MCC and increases one's effectiveness working with diverse populations overall. Therefore, *pedagogical strategies* (i.e., increasing multicultural counseling content and experiences) must be addressed to enhance students' MCC to competently work with diverse populations (Chao, 2013; Constantine, 2001; Constantine, 2002; Holcomb-McCoy & Myers, 1999). From the observer-rater perspective, if trainees' increase MCC, this has a positive correlation with observer-rater perspective of MCC (Constantine, 2001).

Additionally, across all studies investigating disability competencies, training was associated with increasing appropriate case conceptualization, treatment planning, clinical contact, and experiences with persons with disabilities (Kemp & Mallinckrodt, 1996; Strike et al., 2004; Weiss et al., 2010). Therefore, an underlying theme was the significance of *promoting specific courses and increasing contact with persons with disabilities*. Lastly, given the complexity of ASD, researchers addressed students and professionals' preparation, experiences, training, and confidence treating ASD. As a result, counselor educators can contribute to *positive attitudinal development* through *increasing students' self-efficacy, experiences, and training* with persons with ASD (Burnett, 2014; Cascella & Colella, 2004; Dincola & Lemieux, 2015; Plumb & Plexico, 2013; Schwartz & Drager, 2008). Now, transitioning to a critical review of the qualitative studies regarding counselor competence, MCC, disability competence, and ASD competence.

## **Qualitative Studies**

### **Counselor Competence**

After an exhaustive search, I was unable to locate a qualitative study examining counselor competence; however, the current study is a qualitative inquiry and will fill this gap in the literature. In addition, there are several implications that the current study will recognize. First, the study is a phenomenological investigation that hopes to understand and interpret phenomenon in terms of the meaning participants bring to that phenomenon (Denzin & Lincoln, 2013). Secondly, this study will foster the subjectivity of participants from the micro level and acknowledge the participants' point of view of the phenomenon (Glesne, 2016). Lastly, this qualitative study will support current research on counselor competence and/or provide implications for the counseling profession. Thus, it is imperative to investigate the counseling competencies needed to treat children with ASD and their families.

### **Multicultural Competence**

Cook et al. (2015) study examined the how students in the school counseling track developed MCC and social justice advocacy. In addition, the researchers identified how targeted instruction can assist with promoting MCC and social justice advocacy. Therefore, they defined social justice advocacy as “a process of acknowledging systematic societal inequities and oppression while acting responsibility to eliminate the systematic oppression in the forms of racism, sexism, heterosexism, classism, and other biases in clinical practice both on individual and distributive levels” (Cook et al., 2015, p. 126). The authors mentioned the importance of building trainees' MCC and social justice



orientation by engaging in service learning as a way to prepare students for develop MCC and social justice awareness. The researchers collected data using a qualitative content analysis (QCA) of semi-structured interviews to identify themes around developing MCC and social justice advocacy. Their research questions were: (a) *In what ways do practicum students develop MCC and social justice advocacy skills?* (b) *Did experiences differ based on whether or not students engaged in the targeting supervisory curriculum?*

For the pilot study, the authors outlined the research team's positionality and assumptions regarding the research questions. The convenience sample included first year graduate counseling students. There were 21 participants (20 females and 1 male), 19 were Caucasian students, 1 Asian student, and 1 Latina student. Fourteen were raised in suburban settings, 4 in an urban setting, and 3 reported being raised in a rural setting. During data collection, participants had not yet completed an MCC course, but did complete between three to ten courses in the school counseling program. At the completion of the participants' practicum, randomly assigned semi-structured interviews were conducted and included questions based on previous MCC and social justice advocacy research. The interview questions focused on awareness, knowledge, and skills, as well as social justice advocacy.

The participants were randomly assigned to the standard practice group curriculum, which was typical within the school counseling graduate program *or* were assigned to the targeted supervisory group curriculum, where participants were additionally asked to reflect on experiences related to MCC and social justice advocacy. In addition, participants were engaged in discussion and journal writing, as well as assigned specific readings related to MCC and social justice advocacy.

**Data analysis.** Cook et al. explained the rationale for choosing QCA due to the effectiveness of evaluating small groups' descriptive understanding of MCC and social justice competencies. The first step of QCA involved transcribing and developing a coding frame containing main categories and subcategories related to the research questions. The researchers diminished the data into units of coding using structural coding. Furthermore, Cook et al. employed deductive approaches where they used previous work grounded in MCC (see Sue et al., 1992) to guide analysis. Lastly, the researchers recorded the number of times themes were generated within the final coding frame to make comparisons between the standard practice curriculum and targeted supervisory group curriculum.

**Results.** There were two main categories of increasing self-awareness and developing a social justice orientation. The categories contained subcategories, which were obtained through deductive and inductive analysis. For the over-arching category, increasing self-awareness, two subcategories emerged, which included, *increasing self-confidence* as a school counselor and *recognizing biases and privileges*. Within the main category, developing a social justice orientation, three subcategories were identified, which comprised of *holding high achievement expectations* and *promoting equitable educational practice, engage in collaborative efforts, and importance of accessing resources* (p. 132).

Cook et al. qualitative inquiry explored how supervisory curriculum aimed at developing MCC and social justice advocacy skills of school counseling students. As the authors recognized, they were unable to control for information shared across the two practicum placements. However, for the current study, this will not be an issue because

the study is investigating the baseline of participants' MCC working with children on the autism spectrum; thus, measuring supervisory curriculum delivery was not the goal of the study. Additionally, Cook et al. only included participants in the school counseling program and did not measure other track's outcomes (i.e., Marriage Couples and Family Counseling and Clinical Mental Health Counseling). Conversely, the current study will be investigating MCC working with children and families with ASD across professional counseling disciplines (i.e., CSC, LPC, and LMFT) to gain a conceptual understanding. Lastly, the authors discussed triangulation and the trustworthiness of findings. However, they did not provide their positionality on MCC and social justice advocacy in field placement coursework, affecting one's neutrality in qualitative research (Lincoln & Guba, 1982). Therefore, I plan to bracket my position to the research so my perception of the phenomenon does not influence the study's results.

Rogers-Siren et al. (2015) study was a qualitative analysis utilizing consensual qualitative research (CQR) to analyze data based on interviews with ten immigrant college students who had sought out counseling services. The researchers investigated the participant's experiences in their therapy sessions including what they did and did not find helpful, as well as what they did and did not like about their counseling experience. Based on the author's literature review, most immigrants experience some form of anguish as it relates to acculturation stressors that are associated with a variety of mental health symptoms. Further, the MCC of the therapist has a dramatic impact on the counseling experience and counselors' MCC predicted satisfaction and quality of the working alliance. Moreover, much of the research on MCC is based on SPC of counselors; thus, their study investigates the clients' ratings of their therapist's MCC.

Therefore, the study was an attempt to gather immigrant client data regarding the therapists' behaviors they described as positive or negative and culturally sensitive and insensitive.

**Participants and procedures.** The inclusion criteria for the study was (a) either the participant or one of their parents had immigrated to the United State from another country and (b) they were either currently in psychotherapy or had been in psychotherapy in the past. A total of ten contributors participated. All participants saw an array of clinicians (e.g., clinical psychologists, mental health counselors, school counselors, social workers). The PI used a semi-structured interview protocol, which consisted of 20 questions. Trained undergraduate and graduate research assistants on CQR research methods transcribed all interviews.

**Analysis Plan.** Before interviewing the participants, two main themes were predetermined, which were competent and incompetent behavior. These themes were identified after initial reviews of the transcripts and organized the data (phase one). During phase two, the researchers collaborated and compared categories, where discrepancies were noted and the research team came to a consensus. Next, the research team reviewed the transcripts a second time and organized all data according to agreed categories (phase three). Throughout phase four, any discrepancies that were still present were discussed and a consensus was reached. Finally, an outside auditor analyzed the data and provided minor suggestions.

**Results.** Rogers-Siren et al. study identified two overarching themes (a) cultural incompetence and (b) cultural competence in addition to subthemes within each major

theme. Under cultural incompetence, the research team identified lack of clarity about what therapy entails, participants experienced microaggressions and discrimination within sessions that led to discomfort and feelings of disapproval, therapists assumed cultural knowledge of the client and pathologized cultural differences. Additionally, five themes surfaced under the second category, cultural competence. These themes included the counselor being open to learning about clients' culture, using culture in an appropriate way, knowing when culture was not related to the presenting mental health concern, demonstrating patience, and displaying empathy.

While Rogers-Siren et al. informed and supported the existing research regarding what constitutes cultural competence with immigrant populations; there were several limitations to the study. First, the authors did not provide their ontological assumptions and epistemological stance; thus, the reader was unable to differentiate what paradigm the researchers' positioned themselves. In addition, the PI did not cite the creators of the theory CQR. Secondly, the research team did not engage in member-checks to ensure trustworthiness of the data (Denzin & Lincoln, 2013) and relied on an outside auditor. Next, participants saw clinicians from different professional backgrounds, which may have affected results due to the disciplines' standards to teaching MCC. Lastly, the PI did not bracket assumptions regarding their own experiences as an immigrant. These assumptions may have skewed the data to fit the PI's experience. Therefore, the proposed study investigating the SPC of counselors working with children and families diagnosed with ASD will present my position to ensure my subjectivity does not obstruct the results. Furthermore, I will provide a thorough summarization for the relationship between my ontological, epistemological, and methodological position to guarantee congruence.

Additionally, I will employ member-checks to guarantee the data is credible while also bracketing assumptions before, during, and after data collection and analysis (Kline, 2008). Lastly, I will only interview counselors across professions (i.e., CSC, LMFT and LPC) to ensure consistency.

### **Disability Competence**

After a thorough search, I was unable to discover a qualitative study examining disability competence. The current study is a qualitative inquiry and will fill the gap in the counseling literature. In addition, there are a number of implications for the counseling profession the current study will acknowledge. First, the study is a phenomenological investigation that hopes to comprehend and analyze in terms of the meaning participants make of the phenomenon (Denzin & Lincoln, 2013). Secondly, this study will nurture the subjectivity of participants from the micro level in hopes to acknowledge their point of view of the phenomenon (Glesne, 2016). Lastly, this qualitative study will support current research on disability competence and/or provide implications for the counseling profession. Thus, it is imperative to investigate the competencies needed to treat children with ASD and their families, which will offer the counseling profession the first study exploring this phenomenon.

### **Autism Spectrum Disorder Competence**

Werner (2011) investigated what factors motivate students to work with persons with ASD. The author noted, because of the complexity of ASD, it is important to understand professional preference to work with this diagnosis. Thus, the researcher used theory of planned behavior (TPB) to examine the attitudes of students in the health and

social professions toward working with persons with ASD. Werner used TPB to scrutinize the “(1) personal attitudes toward the behavior and individual’s beliefs about the outcome of the target behavior [and] (2) perceived behavioral control incorporates factors that the individual considers to facilitate or impede performance of the behavior” (p. 132). Therefore, the author wanted to explore the feelings and opinions of the participants.

**Participants.** Convenience sampling was used to recruit 42 female students, age ranged from 20 to 33 years old ( $M = 24.60$ ) from universities in Israel. The students represented several departments such as social work ( $n = 10$ ), education ( $n = 8$ ), nursing ( $n = 7$ ), occupational therapy ( $n = 9$ ), and communication disorders/speech and language therapy ( $n = 8$ ). These professions were chosen because they typically encounter persons with ASD. Forty of the participants were undergraduate students and two were graduate students. Participants were asked a series of demographic questions regarding exposure to the topic of disabilities through coursework.

**Data collection.** Werner’s study used a TPB-based elicitation questionnaire, where the participants were asked to list their beliefs in response to six open-ended questions. For example, one question asked, “Any issues come to mind when thinking about working with children with autism?” Questionnaire completion lasted approximately ten minutes.

**Data analysis.** Data was examined using content analysis by recognizing key themes without using preconceived categories. Werner used the participants’ words and categorized common words between respondents. Therefore, “After extracting and

labeling the emerging themes, the author listed them in order of frequency, thus forming a list of belief-based measures for attitudes and perceived behavioral control” (p. 133).

The author only included themes that were identified five or more times.

**Results.** Twelve attitude themes and seven perceived behavioral control themes were identified. In addition, based on TPB, the frequencies of themes representing attitudes (93.5%) and perceived behavioral control (87.5%) were found. The most frequent theme representing attitudes towards ASD was viewed as difficult and demanding. Respondents also believed working with this population would be physically and emotionally tiring and necessitates a high degree of energy, tolerance, and commitment and would lead to burnout. The third theme was perceived communication difficulties in understanding and receiving feedback between professional and client. The fourth theme was the view that working with persons with ASD would be frustrating due to the small steps of change that measure impact of one’s work. The fifth theme was the issue of stigma based on the statements made (i.e., “...people with ASD are not hygienic,” p. 133). Additionally, students reported a lack of information might contribute to the avoidance of working with ASD. However, respondents believed working with the population would be rewarding and perceived it as an opportunity for professional growth. The main behavioral control was related to the personal characteristics of the individual such as emotional intelligence, patience, caring, etc. Another behavioral characteristic that would assist with easing into the field of ASD is previous acquaintance and experience in the field. In addition, professional knowledge and training was deemed necessary to increase skills and confidence working with the population. Lastly, the availability of support within and outside the workplace was considered necessary.



Several limitations exist for this study. First, the sample was female and did not convey what race/ethnicity the participants represented. The current study will attempt to represent the counseling profession through the licensing and certification of participants (e.g., LPC, LMFT, and CSC). Secondly, Werner did not specifically examine previous knowledge or contact with persons with ASD. The current study will be investigating the participants' experiences with ASD pre and post educational training; thus, will address this limitation. Lastly, the author did not report any trustworthiness tactics when engaging in qualitative research. For example, Werner analyzed the data and did not utilize an outside auditor to ensure themes were representative of the data. Thus, the current study will establish confidence through several elements of trustworthiness (Lincoln & Guba, 1985).

### **Summary of qualitative findings**

In sum, these studies present helpful data on how counselors develop MCC and social justice advocacy, as well as perceived preparedness of counselors' MCC when treating those who identify as immigrants. In addition, the characteristics that motivate students to work with ASD. Across all studies investigating MCC, themes yielded similarities including the benefit of *integrating a targeted supervision curriculum* in counseling programs to build student's self-awareness and social justice orientation. *Pedagogical strategies* must be addressed to enhance students' work with diverse populations and dismantling societal inequalities (Cook et al., 2015). From the client's perspective, helping professionals' demonstrate cultural incompetence and cultural competence in session. Thus, *a respect for one's worldview, clinicians' willingness to address reactions, openness to learning, and humility to address one's lack of knowledge*

can all combat cultural incompetence (Rogers-Siren et al., 2015). Additionally, given the complexity of ASD, it is important to understand what motivates helping professionals to work with this specific population. Therefore, an overarching theme was the importance of *promoting specific courses and increasing contact with persons with ASD* (Werner, 2011). Furthermore, educators can contribute to *positive attitudinal development* through *increasing one's knowledge, training, and previous experiences*, as well as *contact* with persons with ASD (Werner, 2011). These themes cannot be substantiated from the qualitative research regarding counselor competence and disability competence, because at this time, such studies do not exist.

### **Purpose of the Present Study**

A comprehensive review of the literature provides insight into how helping professionals develop counseling competencies, MCC, disability competencies, and ASD competencies. However, there remains a gap in the counseling literature addressing the specific competencies needed to treat children on the autism spectrum and their families. Therefore, this study aims to explore the rich descriptions of phenomena (Groenewald, 2004) and meaning participants' make of their experiences working with this population (Denzin & Lincoln, 2013). Through a phenomenological inquiry, I will investigate counselors' SPC working with children with ASD and their families.

Chapter 3 provides a more detailed explanation of the methodology of the study and design. Subsequent chapters will provide the study's results, as well as a discussion of the results, conclusions, and implications for future research.

## CHAPTER 3

### METHODOLOGY

#### **Introduction**

For Chapter 3, I delineate the rationale for the study, as well as my methodological approach. Before outlining the precise procedures of acquiring information around the phenomenon of counselors' SPC working with children and families with ASD, I outline my clear ontological and epistemological position of the social phenomenon. I also detail my professional background as a counselor and my subjectivity to the research. Next, I provide a: (a) rationale for the selection of participants and sampling method, (b) specific data collection procedures, (c) data analysis, and lastly, (d) elements of trustworthiness.

In Chapter 1, I described the theoretical framework, MCC (Sue et al., 1992), and tied this theory to counselors' SPC (i.e., life experiences, educational and clinical training experiences, and the post-graduate experiences). In Chapter 2, a comprehensive review of the literature from various disciplines provided insight into developmental components of counselor competencies, MCC, disability competencies, and ASD competencies. Counselor competence is a complex, multidimensional construct (Sommers-Flanagan, 2015); however, based on the MCC framework, counselors must cultivate awareness, knowledge, and skills to work with diverse clientele. Since persons with disabilities are recognized as a "multicultural concern" (Smith et al., 2008) and ASD is categorized as a

developmental disability, logically, ASD falls under MCC. Yet, there remains a gap in the counseling literature addressing the specific counseling competencies needed to treat children on the autism spectrum and their families. Further, how counselors develop their ASD counseling competencies. Therefore, this study represents the experiences of counselors working with children and families with ASD, where I attempted to understand the phenomena from the respondents' perspectives (Qazi, 2011). I investigated counselors' SPC through semi-structured, depth interviews. The data was used to answer the follow research questions:

RQ1: How do counselors describe their experiences counseling children diagnosed with ASD and their families?

RQ2: How do counselors describe their development of clinical competence working with children diagnosed with ASD and their families?

The function of this study was to acquire the essence of counselors' SPC to work with children on the autism spectrum and their families and therefore, construct explanations and enhance the profession's understanding of the development of expertise working with this diagnosis (Mason, 2002). To capture the phenomena, I utilized Moustakas' phenomenological model.

Phenomenology is an extension of the constructivist paradigm and searches for a deeper understanding of everyday experiences (Morrissette, 1999). Further, "Phenomenology is a tradition congruent with counseling because assessing detailed information about client experiences is a natural part of professional practice... has strong philosophical underpinnings and is the ideal approach for understanding individuals' common experiences of a phenomenon" (Hays & Wood, 2011, p. 291).

Because phenomenology as a methodological approach is closely aligned with counseling, I next provide a detailed explanation of my ontological assumptions and epistemological stance.

### **Epistemological and Methodological Approach**

**Researcher's ontological and epistemological assumptions.** When forming one's claim to research and perspectives of the world, qualitative researchers emphasize the need to be transparent about one's ontological assumptions and epistemological beliefs (Denzin & Lincoln, 2013). The association related to one's ontology, epistemology and methodology is a "directional relationship... between what a researcher thinks can be researched (their ontological position), linking it to what we can know about it (epistemological position) and how to go about acquiring it (their methodological approach)" (Grix, 2002, p. 179). Therefore, my ontological and epistemological assumptions were a foundational guide (Hays & Wood, 2011) and shaped by the experiences I brought to the research process (Grix, 2002).

Having congruence between my ontological, epistemological, and methodological positions was imperative to logically flow through my research (Denzin & Lincoln, 2013). Based on ontology, the question arises: How do I know what I know? When I consider my ontological assumptions, I believe individuals and systems I interact with on a day-to-day basis socially constructs reality. The relationships I hold with others, the intersection of my identity, my culture, and my values all interrelate and make up who I am, which shapes my choices, my actions within the world, and the meaning I make of the world around me (Denzin & Lincoln, 2013). Thus, from my perspective, the nature of

reality is socially formed and “will be constructed differently by people, depending on the meaning they make of their world” (i.e., constructivism; Allison & Pomeroy, 2000, p. 94). Throughout the counseling process, counselors approach clients with foundational assumptions about the practice of counseling (i.e., theoretical orientation). Therefore, counselors apply their theoretical orientation appropriately during the period of counseling in consideration of clients, setting, and treatment concerns (Hays & Wood, 2011). My overarching theoretical orientation, humanism, enhances my practice with clients and fosters the dignity of every human being and a strength-based perspective to understanding the human experience; thus, I believe it coincides harmoniously with the constructivist paradigm (Association for Humanistic Counseling, n.d.). Coming from a person-centered approach, I believe individuals’ reality is developed through internal and external experiences and how they perceive the world has a direct impact on self-regard (Rogers, 1961). Moving from my personal ontology to my epistemological view, I share my position on the nature of knowledge.

As Allison and Pomeroy (2000) stated, “epistemology fundamentally refers to the nature of knowledge... questioning the sources of knowledge, the assumptions upon which it is based, and therefore questioning what we “do know” and “can know”” (p. 92). Because I am an LPC, my epistemological assumptions overlap with the constructivist approach (Hays & Wood, 2011), which seeks to explore meaning and understanding from the perspectives of the respondent (Denzin & Lincoln, 2013). As an LPC, I recognize the importance of understanding the client’s social reality and how this reality impacts them (Grix, 2002). I believe our narratives, journey, and experiences account for who we are within our reality. As a humanist, I honor the differences between people based on their

subjective meaning and perspectives of reality (Grix, 2002). Moreover, the field of counselor education promotes a constructivist pedagogical approach, where self-exploration, appreciating multiple viewpoints, promoting existing strengths, and greater equality between instructor and student is supported (Bernard & Goodyear, 2014; Brubaker, Puig, Reese, & Young, 2010). Thus, based on my ontological and epistemological perspective, my position is congruent with the constructivist paradigm.

### **Researcher Positionality**

Researcher subjectivity poses a significant threat to the credibility, transferability, and trustworthiness in qualitative research (Qazi, 2011). Transparency throughout the qualitative investigation is essential because the *researcher is the instrument* (Patton, 2001). In phenomenological research, the Epoché process is the act of setting aside prejudgments and preconceived ideas of the phenomenon to ensure a “purified consciousness” and to challenge oneself to be transparent (Moustakas, 1994). Therefore, I fully reflected my position and assumptions throughout the implementation and analysis of the study to understand my role in the process (i.e., active reflexivity; Mason, 2002). Furthermore, when participants did not respond with similar experiences, I probed further to ensure *their* voice was highlighted and acknowledged the disparity in experiences through analytic memos, and showcased the process through my findings. To highlight my Epoché practice, I will offer my professional background and how it aligns with the study, as well as brief responses to the three constructs under investigation (i.e., life experiences, educational and clinical training experiences, and the post-graduate experiences).

**Professional background.** I hold a Master's degree in Clinical Mental Health Counseling and have been practicing as a LPC since 2012. For the past three years, I have embarked upon my doctorate in Counselor Education and Supervision at the University of South Carolina (USC). During my time at USC, I wrote a conceptual article on best practices for counselors working with children across the autism spectrum and their families (see Feather, 2016). Before licensure, I worked in a residential setting treating children with LFA and was an associate teacher at a K through 12 school for autism teaching children with HFA. In addition, I have been a practicing counselor for five years and supervisor for three years counseling persons with various disabilities. Previously, my education and training has been in the North Central part of the United States.

**Subjectivity.** I believe counselors should have a foundational knowledge of Applied Behavioral Analysis (ABA) to work with children across the autism spectrum. Sheperis, Mohr, and Ammons (2014) affirmed ABA is considered the overarching framework to guide treatment for a child with ASD and many of the main elements can coincide with counseling. Therefore, counselors must understand and implement ABA into practice to be effective when treating children with ASD. In addition, counselors need to have an immense amount of patience to work with ASD. Treatment progress is can be slow and realigning my expectations as a counselor was critical to provide positive treatment to the child with ASD and their family. Additionally, I acknowledge the importance of communicating with all persons who are involved in working with the child with ASD. Because children with ASD are eminently unique, there is no collectively accepted best course of treatment (Feather, 2016; Simpson, 2008); as a result, the child will most likely be connected to specialists outside of the counseling session.



Therefore, communicating with professionals across treatment settings is essential (i.e., multidisciplinary approach). In the same vein, connecting the child and the family to resources outside of the counseling session is also important. Lastly, treatment should be systematically individualized to the child's developmental needs and unique characteristics (Feather, 2016; Layne, 2007). Hence, I believe counselors must be flexible and creative, as well as incorporate the interests, strengths, and limitations of the client and family into the counseling session.

I recognize how personal life experiences nurture one's line of work and interest in working with future clients. For example, I had previous experiences working with ASD in a residential treatment facility and school setting before graduate training. For me, these experiences ignited personal interest, as well as built competencies as it relates to awareness, knowledge and skills when working with ASD. However, my educational training did not enhance my expertise counseling children with ASD and their families. For example, ASD was not discussed during my graduate training and I acknowledge my assumption that counseling professionals do not receive the adequate training to develop one's awareness, knowledge, and skills when working with children across the autism spectrum and their families. I also believe that counselors' post-graduate experiences enhanced their work with the diagnosis.

I can reflect on several post-graduate experiences and mentors who assisted with my overall development. These mentors were from varying professional backgrounds and provided me with rich, immediate feedback and specific insight from their scope of practice. Therefore, I value the mentor relationship and believe it can enhance competence. Another major assumption is that counselors increase competencies when

they are on the job and have direct experience counseling children with ASD and their families. For me, many of my skills developed through trial and error within the counseling room with clients and families with ASD. I acknowledge this is not best-practice, but is how I developed and increased my confidence as a counselor to work with this diagnosis.

## **Participants**

**Request for participants.** I utilized purposeful and snowball sampling methods to recruit participants (Creswell, 2014; Patton, 2002) due to the nature of the study and the identified research questions. I selected purposeful sampling because I needed to recruit participants who had significant clinical experience in the field of counseling and autism. I also engaged in snowball sampling and requested participants to refer counselors they believed fit the criteria for the study. Additionally, the recommended sample size for phenomenological investigations is between 5 to 25 participants (Hays & Wood, 2011). Previous qualitative studies that focused on MCC (see Cook et al., 2015 [21 participants] and Rogers-Siren et al., 2015 [10 participants]) had varying sample sizes. Therefore, based on the average of Cook et al. and Rogers-Siren et al.'s research, I recruited 15 participants. Data saturation was reached after the thirteenth interview (Sousa, 2014); however, the last two participants had worked in the field of autism for over ten years. Therefore, to further validate and enhance the findings, I interviewed the two participants. Participants also received a \$20.00 gift card as a participant incentive.

To answer my research questions, criteria for participation included: (a) hold a LPC, LMFT, or a CSC in the K through 12 school system; and (b) counsel children and

families diagnosed with ASD. The standard was established to ensure counselors were recruited for the study, as well as counselors who identified as having experience counseling children and families with ASD. I recruited participants through organizations that employ counselors and clinical interest networks such as: (a) Barbara Melton's List (i.e., statewide listserv that connects helping professionals to available trainings, serves as a resource for advertising, and more); (b) University of Akron's Chi Sigma Iota listserv (i.e., past graduates of the counselor education program); (c) community mental health center in Northeast, Ohio; (d) Richland II school district's Director of Counseling; (e) and referrals from participants to expand the sample ('snowball sampling'). Through the organizations and clinical interest networks, I invited participants through email (see Appendix A). Ohio was included because that state and South Carolina have similar licensing protocols and procedures to license mental health professionals in the state; however, in Ohio, an LPC can upgrade their license to a licensed professional *clinical* counselor (LPCC) after completing two years of training experience under a supervisor with a LPCC designation (i.e., LPCC-S). Additionally, LPCC applications must take The National Clinical Mental Health Counseling Examination (NCMHCE) before being credentialed as an LPCC. The upgraded license in Ohio is similar to the LPC designation in South Carolina except for passing the NCMHCE exam.

***Researcher-participant relationship.*** For the purposes of this study, I introduced myself to participants as a LPC and a doctoral candidate from USC who was interested in understanding how participants' develop their competencies working with children and families diagnosed with ASD. I built a relationship with each participant by engaging in active listening and discussions around ASD. Based on my humanistic perspective and

theoretical orientation, one of the core conditions of person-centered therapy is to establish rapport. Without a solid relationship, connecting with clients will not occur (Rogers, 1961). Therefore, I used basic counseling skills from my theoretical framework to gain a holistic, organic perspective of the phenomenon. Additionally, I used a pre-interview script (see Appendix B) to ensure informed consent was reached before beginning the depth interview.

***Sample characteristics.*** After an extensive review of the literature, I developed a pre-interview questionnaire (see Appendix C). I included 80% of the demographic information used in previous studies. Out of 15 participants, 11 (73%) identified as female and four (27%) identified as male. Thirteen identified as Caucasian, White (87%), one identified as Hispanic, Latina (7%) and one identified as African American, Black (7%). Years of professional experience ranged from 1 to 32, with a mean of eight years. Two of the interviewed participants held a doctorate (Ph.D.) in counselor education and supervision (13%) and 13 of the interviewed counselors held a Master's or Ed.S. degree (87%). Participants represented a variety of specializations, and several participants designated more than one specialization. Ten of the participants were LPCs and LPCC-S from Ohio and South Carolina (67%), two of the participants were an LMFT and LMFT-S from South Carolina (13%), two participants were a CSC from South Carolina (13%), and one participant was an LMHC from Florida (7%). Further, three of the participants identified as dual certified as a CSC and CRC credential (20%). Demographic information for the 15 interviewed counselors is as follows (see demographic Table 3.1 for summary).

In terms of primary work setting, three participants identified as working in a K through 12 school setting (20%), one participant in a private practice setting (7%), one participant in a behavioral program (7%), one in a primary care setting (7%), one in academia (7%), four in a community mental health setting (27%), and four in a residential setting (27%).

Participants were asked their experiences with ASD (Demographic form questions, 8a [“A member of my family or close acquaintance is diagnosed with ASD”], 8b [“ASD was discussed during my academic training”], 8c [“ASD was addressed in seminars and/or workshops I attended”], 8d [“I have recent work experience involving children with ASD (within the past five years)”], 8e [“I have past work experience involving children with ASD (five or more years)”], and 8f [“Other”]). Two of the participants (roughly 13%) identified they had a family member or close acquaintance diagnosed with ASD. Nine of the participants (60%) identified ASD was discussed during their academic training. Thirteen of the participants (87%) identified ASD was addressed in seminars and/or workshops they attended. All of the participants identified they had recent work experience within the past five years involving children with ASD and their families. Ten of the participants (67%) identified they had past work experience five or more years ago involving children with ASD and their families. Two of the participants said they had “other” experiences working with children with ASD and their families with ASD. One participant shared he “collaborat[s] with schools, city and state employees, etc.” and another participant clarified she “works at a school for autism.”

Table 3.1

*Demographic Table (N=15)*

Participant	Credential	Experience (years)	Setting	Sex (Gender)	Highest Degree	Race/Ethnicity
1	CSC, LPC/I (SC)	1	School Setting	Female	Ed.S.	Hispanic, Latina
2	CSC (SC)	11	School Setting	Female	M.Ed.	Caucasian, White
3	LPC (OH)	3	Community Mental Health	Male	M.S.	African American, Black
4	LMFT/S (SC)	5	School Setting	Female	M.A.	Caucasian, White
5	LPC (SC)	3	Primary Care	Male	M.A.	Caucasian, White
6	LPC-S, CSC (SC)	10	Academia	Female	Ph.D.	Caucasian, White
7	LPCC-S (OH)	9	Community Mental Health	Male	M.A.	Caucasian, White
8	LPCC-S (OH)	6	Community Mental Health	Female	M.A.	Caucasian, White
9	LPCC (OH)	6	Residential Setting/Community Agency	Female	M.Ed.	Caucasian, White
10	LPCC (OH)	9	Residential Setting/Community Agency	Female	M.A.	Caucasian, White
11	LPCC-S (OH)	6	Residential Setting/Community Agency	Female	M.A.	Caucasian, White
12	LPCC, CRC (OH)	32	Private Practice	Female	M.Ed.	Caucasian, White
13	LPCC (OH)	4	Residential Setting/Community Agency	Male	M.A.	Caucasian, White
14	LMFT (SC)	5	Behavioral Program Agency	Female	M.A.	Caucasian, White
15	LMHC (FL)	10	Community Mental Health	Female	Ph.D.	Caucasian, White

*Notes.* Licensed Professional Counselor-Intern (LPC/I), Licensed Professional Clinical Counselor-Supervisor (LPCC-S), Licensed Mental Health Counselor (LMHC)

## Data Collection Procedures

**Depth interviews.** Depth interviewing is a qualitative research method that involves conducting rigorous individual interviews with a small number of respondents to explore perspectives of a particular phenomenon (Boyce & Neale, 2006). Because depth interviews are prone to researchers' subjectivity, I implemented a guiding protocol to ensure consistency across interviews (Knox & Burkard, 2009). Furthermore, I developed an interview guide (see Appendix D) based on a review of the literature and pilot interview. The pilot interview was conducted with a current doctoral student who has an extensive clinical history working with children across the autism spectrum (i.e., LFA to HFA). This individual provided direct, as well as indirect feedback on the usefulness of the interview questions. For example, when I used the word "competency," I perceived that the participant became somewhat more guarded and I decided that the word 'competence' may inadvertently create a barrier between the participant and myself; thus, making it difficult to acquire all significant information around their experiences working with ASD. Further, during my dissertation proposal, I was provided direct feedback on my interview questions. For example, my interview questions were too leading toward the theoretical framework (i.e., MCC). Therefore, I honored phenomenological inquiry by being flexible, respecting the participants' authenticity (Rogers, 1961), and allowing the participant to *potentially* lead me to awareness, knowledge, and skills competencies. Additionally, semi-structured interviews and open-ended questions were used until data saturation occurred (Sousa, 2014).

The depth interview was the primary data-gathering source to help construct participants' distinct perspectives regarding the research questions. The main interview

questions were cross-referenced to the study's research questions to ensure a fit between all aspects of data collection and analysis (Anfara et al., 2002; Kline, 2008). Furthermore, I outlined several follow-up questions to expand explanation of concepts that emerged (Rubin & Rubin, 2005). Additionally, I identified probes to ensure clarification and richness to the interview (Rubin & Rubin, 2005). The depth interviews lasted between 26-64 minutes to thoroughly answer all questions and were recorded with an audio recorder. The semi-structured interviews with the 15 participants yielded approximately 9 hours and 45 minutes of audio-interview data or 283 pages of verbatim interview transcription data. A transcriber transcribed the data verbatim and to ensure accuracy, I sent transcription directly to the participant to validate what was written. Participants were also given the opportunity to elaborate or change any of their responses from the depth interview. Lastly, based on Moustakas (1994) phenomenological model, data analysis must occur after the first interview is transcribed. Thus, I listened to the interview no more than 24 hours after the depth interview to ensure consistency across interviews and for the *horizons* of the data to emerge.

Data analysis began immediately after the first interview. I engaged in an iterative process where I simultaneously analyzed, memoed, and reflected on the process, which assisted with identifying emerging concepts (Glesne, 2016). By closely engaging in the inquiry process, I was able to recognize issues with my data collection and analysis early on. For example, I realized through analytic memos that I was too leading with my interview questions, which ultimately affected data collection. More specifically, at the beginning of the data collection phase, I always started the interview with the question, "How, if at all, did your educational training contribute to your expertise working with



ASD?” There was typically a slight pause and an awkward exchange because most of the participants did not have any graduate training experiences, thus, built a barrier between the participant and myself. I realized quickly I needed to be more open and let the participants guide the inquiry. Therefore, I changed my approach and instead asked, “How did you come to work with ASD?” This question was more natural and empowering and allowed the participant guide the interview process.

**Focus group.** As the secondary data collection source, I wanted to facilitate a focus group around participants’ experiences working with ASD. Four of the participants volunteered to be a part of the focus group. Two were CSCs, one was an LPC, and one was an LMFT. Unfortunately, two of the participants dropped out due to unforeseen circumstances leaving only two participants for the focus group. Thus, I cancelled the focus group and did not obtain data through this data collection source.

**Analytic memos.** Memo writing is an essential element of phenomenological inquiry. Saldaña (2016) asserted, “The purpose of analytic memo writing [is] to document and reflect on: your coding processes and code choices; how the process of inquiry is taking shape; and the emergent patterns categories and subcategories, themes, and concepts in your data” (p. 32). Analytic memos are fundamental to providing an audit trail so there is a greater level of transparency (Lincoln & Guba, 1985; Saldaña, 2016; Shenton, 2004). Furthermore, analytic memos are opportunities for myself as the PI to reflect on my positionality and to prevent the data from being prematurely categorized (Groenewald, 2004; Saldaña, 2016).

Throughout the course of analysis, I kept detailed analytic memos to document and reflect on the coding process, the course of inquiry, and the emergent categories from the data (Saldaña, 2016). After each depth interview, I engaged in a systematic reflection, which included: (a) listening to the audio data, and (b) writing an analytic memo, where I reflected on the interview and concepts that were discussed. After the first interview was transcribed, horizontalization occurred. I engaged in a systematic process, where I read the entire transcript before engaging in data analysis (i.e., horizontalization). I copy and pasted each participant's horizontalized statements (i.e., meaning units) into a separate document; thus, leaving only horizons. Further, I organized the meaning units into three sections based on the participants' personal experiences, educational and training experiences, and post-graduate experiences. The horizons document reflecting all of the participants' experiences yielded approximately 847 horizontalized statements of data. Next, I clustered the meaning units into common themes by employing a deductive approach to guide analysis of the textural descriptions of the experience. By engaging in a deductive approach, I grouped data around my theoretical framework, MCC. Data that fell outside of the MCC framework was analyzed using an inductive approach to guide analysis of the textural descriptions of the experience. To further assist with the grouping of the horizontalized statements, I went through two rounds of coding methods. Coding process subsequently described under 'organizing, analyzing, and synthesizing data' section.

## **Data Analysis**

**Phenomenology.** The phenomenological approach “involves a return to experience in order to obtain comprehensive descriptions that provide the basis for a

reflective structural analysis that portrays the essence of the experience” (Moustakas, 1994, p. 13). Further, like Rogers’ (1961) person-centered approach, phenomenology is meant to understand the inner-subjective (i.e., inner- world) of the client’s experience. Hence, I used Moustakas’ phenomenological model; a model typically used in counseling research (Hays & Wood, 2011). The aim of the model is to determine what the experience means to the participants (i.e., Level I; naïve descriptions through open-ended questions and dialogue) and provide a comprehensive description of the experience (i.e., Level II; researcher illustrates the experience through reflective analysis). However, before the phenomenological inquiry occurred, I engaged in the process of Epoché. Epoché is an attentive and systematic process of relinquishing judgment about the natural world to instead concentrate on the investigation of experience. Once I had an unfettered, receptive stance, I focused on phenomenological reduction. Phenomenological reduction included: (a) bracketing, (b) horizontalization, (c) delimited horizons or meanings, (d) invariant qualities and themes, (e) individual textural descriptions, and (f) composite textural descriptions. Phenomenological reduction is necessary to construct a universal textural description of the phenomenon.

To attend to the taken-for-granted (i.e., life world) experience, I bracketed my assumptions in order to achieve a phenomenological attitude (Moustakas, 1994). Once a phenomenological attitude was attained, I started collecting data. After the first interview was transcribed, horizontalization occurred, where every statement was initially treated as having equal value and represented a segment of meaning. Statements that were irrelevant to the topic, repetitive, or overlapping were deleted; thus, leaving only *horizons* (i.e., the textural meaning and invariant constituents of the phenomenon). Next, the

horizontalized statements (i.e., meaning units) were listed and “clustered into common categories or themes... the themes and meanings are used to develop the textural descriptions of the experience” (p. 118). Then, from the textural descriptions, structural descriptions and the essence of the phenomenon were formulated. Lastly, I presented the data through a model of constructs that connected to the textural and structural descriptions (Hays & Wood, 2011).

**Organizing, analyzing, and synthesizing data.** To organize, analyze, and synthesize data, Moustakas (1994) recommends researchers follow the modified Stevick-Colaizzi-Keen method (SCKM). Therefore, I utilized SCKM, where the procedural steps of analysis are: (a) describing the researcher’s personal experience with the phenomenon under study; (b) selecting relevant non-repetitive statements (i.e., *horizontalization* of the data) from the verbatim transcript; (c) relating and clustering significant statements into *meaning units or themes*; (d) describing the *textural description* (i.e., “what”) of the experience as it relates to the phenomenon, which includes verbatim examples; (e) illustrating the *structural description* of how the phenomenon was experienced; and (f) constructing a composite description of the phenomenon incorporating the *textural-structural synthesis* that represent the group as a whole (Moustakas, 1994; Creswell, 2007).

**Meaning units or themes.** To assist with synthesizing the data into a meaningful whole, I engaged in two rounds of coding. Saldaña (2016) suggested a priori orientation to coding, where the researcher chooses the most appropriate coding method that reflects the essence of the paradigm used in the study. My goal was to directly address my particular research questions as it relates to MCC (i.e., a priori), in addition to engaging

in a more exploratory inquiry. Thus, for the first coding cycle I employed in vivo and structural coding methods. For the second coding cycle, I used pattern coding. The first cycle of coding is a way to initially summarize segments of the data and the second coding cycle is a method of grouping those summaries into a smaller number of categories and subcategories, as well as identifying overarching themes. The coding process was cyclical to highlight the salient features and generate meaningful themes (Saldaña, 2016).

In vivo coding is the practice of assigning terms used by the participant to label a section of data and is more likely to “capture the meanings inherent in people’s experience” (Saldaña, 2016, p. 106). Due to my positionality to the research, I wanted to stay as close as possible to the participants’ voice. Throughout the process, I tracked the codes that were participant inspired by using quotation marks to designate an in vivo code. Additionally, I was mindful to pull on the participants’ generated words as the rich, overarching themes emerged from the data. However, to transcend to conceptual levels of analysis, I balanced the in vivo coding method with structural coding.

Saldaña (2016) asserted, “Structural coding applies a conceptual phrase representing a topic of inquiry to a segment of data that relates to the specific research question used to frame the interview” (p. 98). Because this is an exploratory study, as well as a study grounded in the conceptual framework, MCC, structural coding was an appropriate coding method (Saldaña, 2016). Furthermore, structural coding employs a quantitative technique by determining the frequency of codes across participants (Saldaña, 2016). Quantifying the data helped me as the researcher organize the data, as well as reflect the significance of the theme. After I organized each participant’s

horizontalized statements (i.e., personal, educational, and post-graduate experiences), I labeled the segments of data that characterized awareness, knowledge, or skills competencies to reflect the MCC framework. Data that did not fit the framework were labeled using an in vivo code or structural code that embodied the segment of meaning.

After I completed the first coding cycle, I began the second cycle coding method. I focused on the theoretical connections amongst core and subcategories, where I synthesized the data units into themes across all of the transcripts that formed a master narrative of the phenomenon (Saldaña, 2016). I documented the correlation process through analytic memos and outlining a comprehensive description of the experience. When a potential category was identified, I compared the category to the participants' verbatim experiences to ensure the segment of meaning represented the participants' experiences appropriately. Overall, this study addressed two research questions, which focused on the participants' experiences, as well as competency development counseling children with ASD and their families. The findings are summarized through a theoretical model of ASD counselor competency development. I first present the results and then provide a clear outline of the model.

**Data organization and protection.** I organized the data using Microsoft Office (e.g., memos, coding process, and transcriptions) and Microsoft Excel (e.g., relevant tables). Utilizing Microsoft Office allowed me to organize and engage in a quick recall of the analysis, where information was delegated and summarized to verify overarching themes, categories and subcategories.

Qualitative researchers are charged with protecting the participants' identities, but also providing detailed, accurate accounts of study respondents (Kaiser, 2009). Therefore,

Kaiser (2009) asserted, researchers must “collect, analyze, and report the data without compromising the identities of the respondents... and must be addressed throughout the study” (p. 1634). I also implemented safeguards to protect participants’ confidentiality. Participant information was stored on a password-protected computer that only I can access. All identifying information was kept separate from the coding. I asked participants to provide pseudonyms for the study to protect all identifying information. All methods used (i.e., procedural and situational ethics) to safeguard participants are forms of credibility for qualitative research (Tracy, 2010).

### **Trustworthiness of Study**

Experts in qualitative research establish confidence in findings through the concept of trustworthiness and its elements of credibility, transferability, dependability, neutrality, and confirmability for evaluating qualitative research (Lincoln & Guba, 1985). To increase rigor, I employed prolonged engagement, triangulation, reflexivity, thick description, member-checks and an external auditor (Hays et al., 2016). I provide a clear justification below for all of the strategies to increase trustworthiness.

**Credibility.** Lincoln and Guba (1985) argued ensuring credibility is one of the most important factors in establishing trustworthiness. One way to achieve higher levels of credibility is through prolonged engagement between the participants and myself in order to gain adequate understanding of the phenomenon (Lincoln & Guba, 1985). Prolonged exposure with participants occurred through in-depth interviews that lasted between 26-64 minutes. Accordingly, I have spent the last two years immersed in the research on ASD and its impact on the counseling profession. In addition, I have counseled and worked with children on the autism spectrum, as well as their families

over the past six years. This experience established my prolonged engagement with the practice and research of working with ASD and building my clinical competence with this specific population.

While my prolonged exposure to the phenomenon may support the credibility of the findings, there is also a greater risk of researcher subjectivity affecting the interpretation of data (Patton, 2002). However, I intentionally practiced reflexivity by bracketing my assumptions and beliefs before, during, and after (Shenton, 2004) to establish whose reality is whom when it comes to the co-construction of meaning (Denzin & Lincoln, 2013). In addition, I worked to achieve credibility through the use of member reflections (i.e., member checks; Tracy, 2010), which is considered the single most important provision to bolster trustworthiness (Shenton, 2004). After each interview, I shared with participants I was going to send the transcription for their review, feedback, as well as if they would like to elaborate on their answers. I also included the interview guide for their convenience. Only one participant responded and stated she “read the first five pages and decided [I was] spot on.” Lastly, I gathered multiple types of data to ensure data was not drawn from a single source, individual, or process of data collection (Creswell, 2014). This process is called crystallization. More specifically, engaging in crystallization opens up the research process to a more complex, in-depth understanding of the issue (Tracy, 2010). Therefore, I engaged in crystallization by inviting LPCs, LMFTs and CSCs to triangulate responses across diverse data sources.

**Transferability.** Lincoln and Guba (1985) suggested the researcher provide adequate contextual information about the fieldwork as it relates to the study’s setting and population. Offering sufficient thick description will enable future researchers to



evaluate if the findings are transferable to their own line of work, as well as compare instances of the phenomenon described (Kline, 2008; Shenton, 2004). Therefore, I strived to provide sufficient detail and rich description as it relates to the participant population, setting, and phenomenon.

**Dependability.** Dependability is concerned with the likelihood the results would be obtained if the study were conducted with the same subjects or with subjects of a different context (Shenton, 2004). Therefore, I provided an in-depth methodological description to allow the study to be replicated. Additionally, to strengthen dependability, I made all aspects of the analysis process open to inspection and provide readers an “audit trail” to reveal how the horizons emerged (see Appendix E and F; Anfara et al., 2002; Lincoln & Guba, 1985).

**Neutrality.** Based on Patton (2002), the researcher needs to be reflective about their voice and perspective. Mason (2002) described reflexivity as “thinking critically about what you are doing and why, confronting and often challenging your own assumptions, and recognizing the extent to which your thoughts, actions, and decisions shape how you research and what you see” (p. 5). Thus, I bracketed my position and assumptions throughout the research process so my perceptions did not influence the study’s results. In the aforementioned section, I outlined my positionality in regards to counselor competencies development to work with children across the autism spectrum and their families. Furthermore, throughout the research process, I was mindful to set aside my assumptions so that the true experiences of participants were reflected in the analysis and was keenly aware when my position was affecting data collection. For example, during my first interview, when the participant was sharing her experience, I

categorized the experience before she was able to label it herself. I quickly rectified the error and encouraged her to classify the experience. When she did, I realized her label was completely different from mine.

**Confirmability.** Confirmability refers to the degree in which results can be confirmed or supported by others (Patton, 2002). Moustakas (1994) asserted, “Confirmation is achieved by repeated looking and viewing while the phenomenon as a whole remains the same” (p. 47). In the current study, I offered several methods of confirmability. First, I utilized an external auditor who has a professional background in rehabilitation counseling, as well as phenomenological inquiry. I involved an external auditor who challenged my findings and noted discrepancies. Lastly, I engaged in a peer debriefing where my findings were challenged and a consensus was reached.

### **Summary**

Currently, there is no qualitative study investigating the counseling competencies needed to treat children diagnosed with ASD and how, if at all, these competencies develop overtime. Qualitative inquiries, specifically phenomenology, bestow the capacity to generate meaning based on the rich descriptions of phenomena and meaning participants make of their experiences. Thus, the phenomenological tradition may enhance findings by capturing rich descriptions of counselors’ SPC related to their: (a) life experiences; (b) educational and clinical training experiences; and (c) post-graduate experiences to treat children with ASD. These three constructs were connected to the established MCC standards, which center on three main counseling competencies of

awareness, knowledge, and skill. The following chapters contain results of the data analysis, a discussion of those results, and implications for the counseling profession.

## CHAPTER 4

### RESULTS

The purpose of the study was to investigate the experiences of counselors working with children and families with ASD and by exploring their experiences; a model for ASD counseling competencies development was established. I collected data through semi-structured, depth interviews with LPCs, LMFTs, and CSCs. Following Moustakas' (1994) phenomenological model, the analysis process began with (a) bracketing, (b) horizontalization, (c) delimited horizons or meanings, (d) invariant qualities and themes, (e) individual textural descriptions, and finally, (f) composite textural descriptions. As is required of phenomenological reduction, I treated every statement initially as having equal value; however, statements that were irrelevant to the topic, repetitive, or overlapping were deleted — leaving only the *horizons*. Through in vivo, structural, and pattern coding methods, I clustered horizontalized statements (i.e., meaning units) into categories and subcategories to expand the textural descriptions of the experience. I grounded the data in the theoretical framework, MCC, of developing one's awareness, knowledge and skills (Sue et al., 1992). Additionally, emerging categories and subcategories outside the MCC framework were also highlighted. Lastly, I formulated structural descriptions to describe the essence of the phenomenon

This chapter begins with a detailed summary of the results that includes a review of the ASD Counseling Competencies Development Model and ends with a presentation of the emergent categories and subcategories and how it promotes the developmental model.

## **Results**

The subsequent developmental model and categories resulted from two rounds of coding as described in Chapter 3. What follows is a presentation of the *structural composite* of the phenomenon (i.e., ASD Counseling Competencies Development Model) and an explanation of the developmental process. Furthermore, a detailed description of the connection between the emergent categories and subcategories as it coincides with the model is also discussed. Under the emergent categories and subcategories section, I begin with an overview of the: (a) MSJCC competencies, (b) exposure, (c) counselor identity, (d) professional orientation, and (e) personal characteristics. To highlight the participants' voice and illustrate the *textural descriptions* of the experience as it relates to the phenomenon, I use direct quotations to support each category and subcategory. The quotations end with the date of the interview and the line numbers of the actual statement. When necessary, brackets in the quotation were used to provide context to something participants' referenced from an earlier part of the interview.

### **ASD Counselor Competencies Development Model**

Figure 4.1 outlines a version of a proposed conceptual model regarding ASD counselor competency development that emerged through the analyses and current results from the study. As I reflected and developed the comprehensive model, I was inspired by

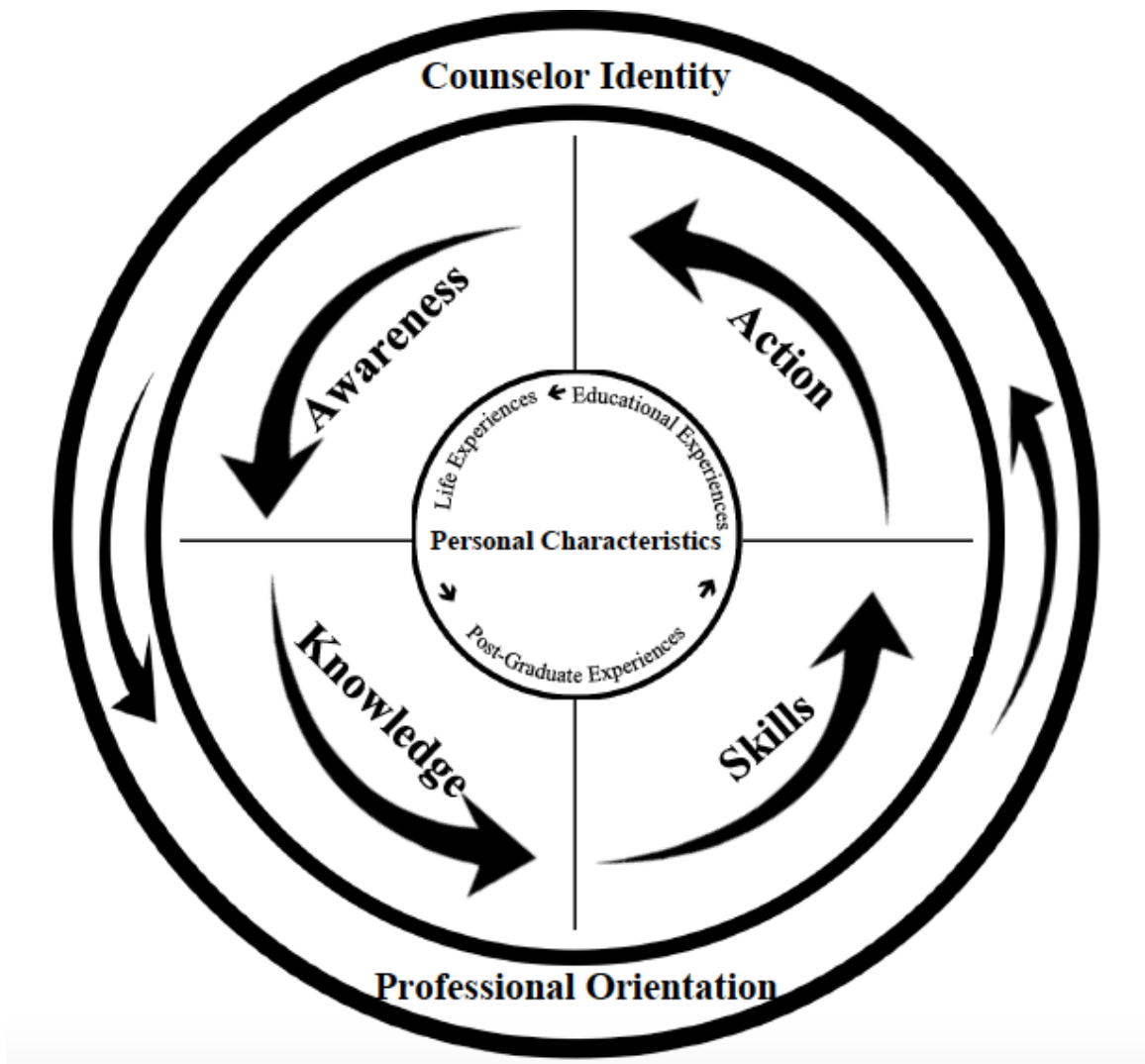
Ratts et al's (2016) MSJCC Conceptual Framework, as well as Bronfenbrenner's (1979) Ecological Systems Theory. For example, Ratts et al's (2016) aspirational competencies (i.e., awareness, knowledge, skills, and action [AKSA]) and the relationship between constructs and competencies was included in the model. Additionally, Bronfenbrenner's (1979) theory regarding human development was also influential. Specifically, Bronfenbrenner supported the notion that when one encounters different environments throughout the lifespan, this influences behavior. These environments are broken up into systems such as the microsystem and the mesosystem of human development. He supported the notion the relationships between the environments have bi-directional influences. At the microsystem level (i.e., personal characteristics and personal experiences), bi-directional influences are strongest and have the greatest impact on the individual. However, interactions with the outer levels (i.e., AKSA, counselor identity, and professional orientation) can still influence the inner structures.

I positioned *personal characteristics* at the center of the model because participants acknowledged these characteristics were essential to work with children with ASD and their families. Therefore, the centralized, personal characteristics were fundamental for successful treatment of the diagnosis. Additionally, the results demonstrated how the cyclical, developmental process between participants' *awareness, knowledge, skills, and action* competencies increases one's effectiveness working with children with ASD and their families. Participants reflected as each of the MSJCC components developed, this ignited the developmental process as the competencies rolled into one another, where one competency could not develop without the other. Participants shared by gaining *exposure* to the diagnosis whether through their life, graduate, or post-

graduate experiences, coincided with the developmental components of MSJCC. Participants also shared how their *counselor identity* and *professional orientation* enhanced their work with this population. All overarching core and subcategories emerged through a cyclical process, as well as bi-directional influences, where one could not develop without the other as reflected through the connecting arrows. Thus, participants developed their expertise to work with the diagnosis through a developmental, cyclical process. Lastly, Table 4.1 summarizes the overarching core and subcategories noting the frequencies represented in the model.

### **Emergent Core Categories**

Research question one focused on *how counselors' described their experiences counseling children and families with ASD*. Analysis revealed participants' life experiences, educational and clinical training experiences, and post-graduate experiences had an impact on their effectiveness working with ASD. Thus, by sharing their experiences, research question two was addressed: *How do counselors describe their development of clinical competence working with children and families with ASD?* Through their experiences, participants described the cyclical, developmental components of MSJCC such as *awareness, knowledge, skills, and action* competencies. By gaining *exposure*, the interaction between MSJCC built their expertise to work with the diagnosis. Additionally, analysis illustrated a *counseling identity, professional orientation, and personal characteristics* to meet the needs of the child with ASD and their family. I describe the overarching categories and subcategories below. The italicized phrases are the respective subcategories under each category.



*Figure 4.1* ASD Counseling Competencies Development Model



Table 4.1

*Frequency of Categories and Subcategories*

Categories and Subcategories	Sample N = 15 % = (100)
<b>AWARENESS</b>	
“Insider status”	7 (47%)
Personal exposure	6 (40%)
Family upbringing	5 (33%)
“Balanced pushing and accepting”: Realign expectations	6 (40%)
Scope of practice	7 (47%)
Assumptions and biases	7 (47%)
<b>KNOWLEDGE</b>	
Graduate training experiences	13 (87%)
Applied behavioral analysis (ABA)	8 (53%)
“Multidisciplinary approach”	7 (47%)
“Mentors”	14 (93%)
Necessary knowledge sets (individual)	6 (40%)
Necessary knowledge sets (family)	8 (53%)
<b>SKILLS</b>	
“Trial and error”	11 (73%)
Necessary skill sets (individual)	
Assessment	7 (47%)
Counseling approach	8 (53%)
Specific “tools”	13 (87%)
Necessary skills sets (family)	
Counseling approach	12 (80%)
Specific “tools”	11 (73%)
<b>ACTION</b>	
Social justice advocacy	6 (40%)
<b>COHESION: AWARENESS, KNOWLEDGE, SKILLS, AND ACTION</b>	
“Exposure”	8 (53%)
<b>COUNSELOR IDENTITY</b>	
“Value specialization”	7 (47%)
Basic counseling skills	11 (73%)
<b>PROFESSIONAL ORIENTATION</b>	
Humanistic perspective	12 (80%)
Strength-based approach	9 (60%)
“Meeting them [client and family] where they are”	11 (73%)
“Person-first perspective”	6 (40%)
<b>PERSONAL CHARACTERISTICS</b>	
“Perseverance”	8 (53%)
“Creative”	8 (53%)
“Flexible”	6 (40%)
“Patience”	6 (40%)
“Taking on initiative”	13 (87%)
“Fulfilling” experience	6 (40%)

## Awareness

Participants shared how they developed their awareness to work with children and families with ASD. Participants highlighted how their life experiences and post-graduate experiences enhanced their awareness of attitudes and biases to work with ASD. None of the participants discussed how their educational training influenced their awareness competencies. Further analysis revealed several subcategories that emerged from the data. Participants discussed how their life experiences provided them an “*insider status*” of the phenomenon and through *personal exposure* and *family upbringing*; this enhanced their expertise working with the diagnosis. In addition, through their post-graduate experiences, participants recognized the importance of *realigning their expectations* as a counselor and acknowledging their *scope of practice*. Lastly, some participants described their *assumptions and biases* entering the field and how they challenged their beliefs. Though, several participants claimed their life experiences prevented biases and assumptions to materialize.

**“Insider status.”** Seven participants either identified being on the autism spectrum or had a family member diagnosed with ASD or a disability. John and Elizabeth share their life experiences:

*John: And that’s [having a child with a disability] been kind of neat too because I get this, and maybe this only matters to me, but I have a little bit of an insider’s status with working with the special needs community. (3.9.16; 133-135)*

*Elizabeth: I’ve kind of honestly felt that I may be on the very, very mild side of it [ASD]... I don’t know if it’s what I feel like maybe, I can kind of relate a little? And it’s also that I don’t want a child- no matter what [their] diagnosis or his or her abilities to not be able to get the help they need. (10.30.16; 128-129, 132-135)*

However, Douglas expresses how having an insider's status does not make one an expert with the particular client:

*I think the challenge is, is a lot of people will say something like, 'well, I've had this one experience so my, my younger brother is diagnosed with autism so I know what it's like and that's not accurate... I can just understand where they've [client and family] come from, but I need them to share with me what that looks like for them. (10.31.16; 196-169)*

**Personal exposure.** Six participants described instances of exposure to a disability and having a "higher tolerance for acceptance" because of these early experiences. Mel reflects on her involvement at her father's church:

*I remember volunteering at church where people in the community with any kind of special need could come... I loved it. It gave me a sense of purpose... I was just really gentle, kind, and gave them attention... [T]hat kinda set me up to not be as judgmental and to not be as standoffish or uncomfortable around any kind of difference. (11.2.16; 479-492)*

**Family upbringing.** Five of the participants described their upbringing that endorsed acceptance, treating people with dignity and respect, and to "not put people into boxes." Kaitlin, Bobbi, and Hillary illustrate their family upbringing and the influence it had on them:

*Kaitlin: [M]y parents did a really good job of explaining the acceptance part... I never thought he [family friend with ASD] was special or he was better, that's just how he was... I think it's deeper than that but, like my parents, race was never an issue, you know, like it was never brought up, like skin color or any sort of disability. They never pointed it out as a label. I guess my view of any sort of disability or diagnosis, even as I progressed through school was, it's not that those kids are weird or different or anything, it's just who they are and it's accepting. (10.21.16; 190-197)*

*Bobbi: [P]eople deserve to be treated with dignity and respect and um, pretty much no matter what. You know, no matter how they come into the world or what happened to them... I mean my mom's values about dignity and respect for all people, that's what I've always kind of followed. (11.23.16; 169-173)*

*Hillary: I didn't have parents who, my parents didn't put people in certain categories... And I was always encouraged to help. (12.8.16; 43-45)*

**“Balanced pushing and accepting”:** **Realign expectations.** Six participants shared the importance of adapting their expectations as a counselor and celebrating the successes whether big or small, as well as finding a balance between pushing the client and accepting them for who they are. Hillary, Alex, Simon, Kaitlin speak to their experiences of regulating their expectations:

*Hillary: And then, looking at the needs of the family and looking at what can that family really do? I can have expectations of the family that aren't ones that they're going to achieve. (12.8.16; 101-103)*

*Alex: If I was a counselor fresh out of the program with no experience with the spectrum, I would probably have different expectations and be frustrated. Their progress is so on, you know, comparatively miniscule. However, with expertise in working with the clients and all that, um, I think that the little progress that they do make is such a huge deal. (12.2.16; 43-46)*

*Simon: [Y]ou know, they [counselors] want to treat and cure. They want to help an individual resolve their depression, they want to help an individual reduce their anxiety, move through their period of grief um, and I think it's a different thing working with individuals who have a neuro-developmental disorder that is not going to resolve itself... [E]ven when you create an environment that is a well-oiled machine and everything functions in a consistent and predictable manner... [T]here's going to be no other setting that can emulate that... and then you're not really setting that individual up for success long-term anyways. I'd say parents have taught me about this, parents who have been accepting of their child's deficits, parents who don't expect perfection from their child, who don't expect their child to change fundamentally. (12.27.16; 484-487; 510-518)*

*Kaitlin: I think you need to know that, as what any individual in the world, but especially with children with autism is that they're all so unique and different and special. And you have to be able to appreciate what makes them special and what makes them thrive before you will make progress with them. And I think that's the hardest thing, is for everyone to understand that autism is, at least from what I've experienced, so frustratingly rewarding. (10.21.16; 348-352)*

**Scope of practice.** Seven participants recognized the importance of understanding one's “limits” when working with ASD. John and Elizabeth share the importance of understanding their scope and referring to a more experienced provider:

*John: [T]he other part is knowing what my limits are. Like, knowing what's better than what I can offer [outside resources and referrals] keeps me from over-extending myself. (3.9.16; 238-240)*

*Elizabeth: [E]ven if I couldn't do it [counseling], because of course I have limits, like everyone and so even if I couldn't reach him [client], I wanted to be able to say, 'okay, well here's this resource, I know this person that could possibly help you' ... I just want every child to be able to get help, that's my biggest thing. (10.30.16; 146-149)*

However, Mel acknowledged the “frequent source of frustration” of “not having any resources” due to the location of where the families were receiving services and feeling like she had to add a differential diagnosis because she “knew they [families and children with ASD] needed help and there was no one else that could help them” (11.2.16; 461-464).

**Assumptions and biases.** Seven of the participants explicitly described the assumptions and biases they held regarding children with ASD and their families. Some of these biases included believing all children with ASD are “really intelligent,” the child was going to be combative and display behaviors in session, and children on the autism spectrum have “zero social skills.” Anna and Elizabeth recall their attitudes and beliefs when working with children with ASD and their families:

*Anna: [Y]ou run into the bias where I think someone from the higher socioeconomic status would have a better understanding of the interventions and the supports that the child needs, but I think in my experience of working with people from a broad range of backgrounds, you really learn that there were so many parents who just felt completely lost. (12.6.16; 294-298)*

*Elizabeth: I remember when I first saw it [ASD] and was like “whoa” and that not being able to speak is not the same as not having anything to say. And so I just remember thinking, ‘oh yea, if you took my voice away all of a sudden, that doesn't mean I don't know what to say’. And so now I try to think about nonverbal children that way. They still have a lot they wanna tell you, they just can't. And so I remember thinking that if they didn't speak there wasn't a whole lot going on. And now I hate that I ever felt that way. (10.30.16; 73-76)*

As illustrated by the quotes, all seven participants who shared their assumptions also described challenging their biases to increase their awareness and ultimately, have a critical consciousness to work with the diagnosis and make the appropriate modifications to session. Furthermore, five participants expressed not having any assumptions or biases when working with children across the autism spectrum and their families. For instance, Douglas shared that because of his personal experience of having a brother with ASD, he did not harbor any biases towards the diagnosis; however, still acknowledged it “does not make him an expert” of his client’s experiences. Additionally, Emily reflects on not harboring any biases towards the diagnosis:

*Biases... You know, I don't, I don't think so, Um, I feel like I have to search my mind and you know, one of my things that I pride myself [on] is being able to work with just about everybody... I always joke around that I have a lot of radical acceptance because it is what it is. I think that's how I would describe myself best. And I'm very coachable, I pride myself on being coachable so I will look for feedback, I want the critique. (11.9.16; 348-249, 359-361)*

## **Knowledge**

Participants described how they developed their knowledge to work with children and families with ASD. All of the participants except for two acknowledged how their *graduate training experiences* had little to no impact on their knowledge base to work with ASD. However, all of the participants described how their life and post-graduate experiences increased their knowledge to work with the children with ASD and their families. Additional analysis confirmed several subcategories that emerged from the data regarding participants’ experiences. Participants discussed how their experiences familiarized them with *applied behavioral analysis* as an effective intervention for ASD, as well as engaging in a *multidisciplinary approach*. Participants shared the importance

of having *mentors* and connecting with colleagues as a way to increase their expertise to work with children diagnosed with ASD and their families. Finally, all of the participants shared *necessary knowledge sets* for both individual and family counseling.

**Graduate training experiences.** Thirteen of the participants shared how their graduate training had little to no impact on their knowledge of ASD. Five out of the 13 participants shared how there was “no educational training... outside of the diagnosis class” that prepared them to work with ASD. More specifically, Simon recalls how his graduate program’s theoretical framework added “value” to his work with ASD:

*I would suggest that it [counseling program] was not significantly impactful in providing direction to the work. Some part of my training in diagnostics and my training in treatment planning are relevant but none of it was um, instructive. The school that I graduated from... would have characterized itself as having a Rogerian bend... and sort of existential principles I think also have some value in recognizing the individual, as a person. (12.27.16; 5-11)*

Jannell shared how her concurrent graduate training as a Board Certified Behavioral Analyst (BCBA) helped her “significantly” to work with ASD:

*I had done the BCBA coursework so that obviously prepared me significantly more than my mental health professional education, but yeah, otherwise it was just the BCBA coursework that did help. (11.22.16; 4-8)*

Moreover, two of the participants shared how their graduate training, specifically a professor infused ASD into the counseling curriculum imparted their competencies. Mel describes how the teacher’s personal experiences as a father parenting a child with ASD, as well as his clinical experience working with families and children on the autism spectrum impacted her understanding of the diagnosis:

*He [teacher who infused ASD into counseling curriculum] had a lot of experience, that was kind of his professional niche, if you will... [T]he biggest thing that I got from him that stuck with me is just an attitude of respect and an*

*attitude of teach me about you and to not assume that we understand them [families and children with ASD] in their experiences... [T]he things that stand out the most to me are his personal experiences, like with his son... [A]nd talking about what it was like to be a parent, and trying to help his child be successful and really being able to focus on what he was good at and having other people see that and be a little more forgiving. (11.2.16; 14-15, 26-28, 42-47)*

**Applied behavioral analysis.** Eight of the participants reflected on the importance of understanding tenets of Applied Behavioral Analysis (ABA) and recognized it as a “source of strength” and “fundamental roadmap” for working with ASD. Simon, Toni and Anna share their perspective on using ABA:

*Simon: [T]hat’s what I meant by throwing stuff at a wall and thinking that that approach for a population with significant deficits in communication or in other cases with deficits in insight that I think you can do damage or at least waste a lot of time and just, I wouldn’t advocate for ABA as the one true gospel, but I do think that if nothing else it is, it informs you: ‘here’s what the assessment should look like, here’s how we draw conclusions.’ Those conclusions are not stated as fact, they’re stated as theory and then we um, that informs approach, that informs intervention and there’s reevaluation of those interventions, I think that that process is a lot better than saying like ‘well, the kid’s depressed, label, provide this,’ you know? (12.27.16; 61-69)*

*Toni: [T]he research says that [using behavioral interventions] we have to. I mean, that’s how I view it. I think that if you don’t then you’re not paying attention to what the evidence suggests as the most effective treatment for people with autism... I do and I don’t understand people’s really kind of negative view on behavior therapy from the counseling perspective... [T]imes have changed and training has evolved quite a bit so you know... [I]t’s our responsibility to learn and integrate those things when we’re treating people with autism. (11.23.16; 138-140, 152-160)*

*Anna: I think it is important to know some of the components of ABA. Um, particularly the idea of reinforcements. Um, because I think it goes a long way to helping understand what can be motivating for the clients and if they don’t feel motivated and they don’t feel like they’re working towards something, then you know, typically they’re not going to be compliant with what it is that you’re asking them to do. (12.6.16; 184-188)*

**“Multidisciplinary approach.”** In addition to the descriptions that highlight the importance of ABA, another recurrent theme in regards to the generation of knowledge was engaging in a multidisciplinary approach (7 participants). Participants’ reflected that



coming from a “collaborative,” team approach is “best-practice” and provides a “different frame to [understanding] treatment” of children with ASD and their families. Toni and Anna explain the value of collaborating with professionals from other disciplines:

*Toni: I mean to me, that [multidisciplinary approach] is one of the keys to working with people with autism. I mean when you have a lifelong developmental disability in which usually people constantly improve, progress even if they're mild on a pretty continuous basis. You get to different stages of life and development and new things pop up. Um, so if you don't have a team of people that you consider or basically refer to for specialized areas of treatment then I think that it does a disservice to the person... So to me, multidisciplinary work with people with autism is just like, it's critical. (11.23.16; 91-98)*

*Anna: [T]hrough discussions and team meetings, be[ing] able to see the different aspects of the whole person that people were focusing on... [S]o where I was often the one who was looking at the feelings and the emotions, they [social workers, teachers, behaviorists, speech pathologists, occupational therapists] had a different perspective and that was helpful to be able to learn from their perspective. (12.6.16; 125-129)*

**“Mentors.”** Fourteen participants engaged in mentoring relationships and identified it was a “significant resource” to “help guide” their work with ASD. Mentors assisted many of the participants to “see different aspects of the whole person to conceptualize the client.” Almost all of the mentors were from other disciplines (i.e., speech language pathologists, special education teachers, behaviorists, intervention specialists), and several participants recognized the families with ASD as mentors as well. Kaitlin, Emily and Jean describe their mentorship experiences and the “valuable” input they received:

*Kaitlin: [A]s a first year counselor just observing, you know, just watching interactions and the things that she [special education teacher] uses you know, if I have any questions I can always go ask her... She's a mentor too... She's made it clear; if you need me, just ask me... [Y]ou have to go out and pursue her, but she's an open door and someone I know that I can go to. (10.21.16; 128-133)*

*Emily: I've got a lot of friends in the field that work at various you know, autism schools, intervention specialists, [and] special education teachers that I'll talk*

*with and I'll bounce new ideas off of. A lot of people who worked through Autism Speaks or other organizations, that's always been helpful with just what's going on right now, what's the new thing. (11.9.16; 316-320)*

*Jean: I've had the benefit of having a lot of experiences here [agency] and I've also had really great mentors who have taught me things, pushed me when you know, I really need to think differently about things. And also, the families. (11.18.16; 478-481)*

**Necessary knowledge sets (individual).** Six of the participants discussed how counselors must know the diagnostic criteria for ASD. Kaitlin shared how important it is to understand the child's needs and development, but also *keeping that safe space, but expanding the bubble* (10.21.16; 92). Similarly, because children with ASD may display difficulties in session due to their symptoms, Alex reflects on the importance of identifying triggers:

*[Y]ou would have to be aware that safety is first and foremost the primary concern. Um, with this population I think that being able to identify triggers for certain clients whether you know, there was one client where certain words would be a trigger... [B]eing aware of each client's triggers and tolerance level so the child can tolerate group. (12.2.16; 81-85)*

Jannell also outlines the importance of understanding how “exhausting” working with children with ASD can be:

*[I]t can be very exhausting. I think the hardest thing is when you work on the something over and over and over again and you don't see the progress being made but then, the progress happens... And sometimes it comes in lumps; sometimes it comes in very small pieces of progress. It, I would say it is probably the hardest thing. (11.22.16; 90-94)*

Lastly, several participants shared how traditional counseling may not always be appropriate to working with children with ASD. Florence reflects on her experience of creating curriculums for clients with ASD and how it is very different from “traditional” counseling:

*[W]e [counselors] need to make it visual, we needed to make it on their level so they [can] understand. It wasn't the typical like sit around and process information for three hours. And it needed to be hands on, it needed to be concrete and it needed to be something they could understand... I think again it was a lot of my experience of understanding how best to communicate with clients similar to ones on the spectrum and learning how to just work with those individuals. (12.27.16; 73-78)*

**Necessary knowledge sets (family).** Eight participants recognized the importance of approaching their work from a family systems perspective so they were able to “see the bigger picture” and “transform the system.” Jannell and Mel explain the value of understanding the family as a whole:

*Jannell: [B]eing able to have that systematic background and the systematic understanding has allowed me to kinda see the bigger picture and not just treat the kid but also treat the family. (11.22.16; 130-132)*

*Mel: I can help you [parents] understand this diagnosis, and I can help you understand how to interact with this child but until you address your issues [family dynamics], you can't expect this kid to recover... So, that's the mental health word. To recover. Um, that's not realistic, and that's not fair. (11.2.16; 153-156)*

As Hillary describes, it is not only important to address ASD from a family system perspective, but to also set reasonable goals that will work for the family dynamic:

*[B]eing very realistic about their goals because, if you're sitting there working with the family that has, more often than not, one child with autism, another one with a different diagnosis and one that's acting out because the other two are getting so much attention. So if you have that much going in a system to say, "Oh, well every night you need to go home and do this." Well, that's bullshit. That's not going to work for the family. So having realistic goals for the family and listening to the family, not giving it to them. You're creating goals with the family. (12.8.16; 101-111)*

Furthermore, several participants emphasized the importance of understanding that families will be experiencing a range of emotions regarding the child with ASD. Toni and Mel share their experiences working with the families:

*Toni: And I mean, listen, those people that are more relieved by it, they also have those moments of, they'll grieve and [experience] sadness and whatever, anger, of course... but I think the people that I worked with had more of that, optimistic perspective; embodied that kind of emotional reactions of relief when they received a diagnosis which, was sort of different from those who were more grief focused. [They] tended to be the people who you know, viewed the diagnosis very pessimistically. (11.23.16; 138-140, 152-160)*

*Mel: I think initially parents come in and they want a diagnosis... [T]here's a sense of relief when they get a diagnosis, it's kinda like, 'okay, this is it, I'm not crazy. There's a name for this. There's other people who have experienced this.' They want to learn about it and I think that brings a sense of relief in a lot of ways. And once they get past that stage, I try really hard to say, 'let's not just look at this person as a list of symptoms'... I try to look at this kid as a person. (11.2.16; 95-101)*

Later during the depth interview, Mel reflects on her work with parents who were processing their grief of not rearing that quote on quote, typical child:

*Mel: [I]t's easier to get there [work through the grief and get family members to understand their child] with a healthy parent than with the other ones... One particular mom was very difficult. She was very, very stuck in that place of anger and resentment and taking everything out on her child. (11.2.16; 124-127)*

## **Skill**

Participants described how they developed their skills to work with children and families with ASD. A majority of the participants acknowledged that their skills were developed through their life and post-graduate experiences. More specifically, participants described building their expertise through *trial and error*. Moreover, all of the participants shared *necessary skill sets* for both individual and family counseling. Additional analysis confirmed several subcategories that emerged from the data under the necessary skill sets. For individual counseling, participants outlined skills that related to *assessment, counseling approach*, and lastly, *specific tools* to work with children with ASD. When addressing the families with ASD, participants shared their *counseling approach* and *specific tools* to work with the family system.

**“Trial and error.”** Eleven of the participants acknowledged their skills were developed by “actually doing the work” and “learning as you go.” Emily, Simon and Bobbi explain their skill development through “firsthand” experience:

*Emily: Honestly, some of it [process that built expertise] was research on the Internet and the other part is, trial and error... So, each client that I had, I learned a significant amount of what types of interventions work. And again, every child with autism is so different that some are more verbal and then others, some understand more than others. (11.9.16; 114-117)*

*Simon: How I developed whatever knowledge base I have, that would’ve come almost entirely from trial by fire, or firsthand experience. (12.27.16; 82-83)*

*Bobbi: And certainly you know, seeing kids, meeting kids and talking to families, you know, you learn firsthand and that’s better than any other way. Better than reading or anything else... [T]here are no two people alike... [T]here isn’t one protocol for you know, autism. There’s the spectrum, everything is different. (11.23.16; 30-32, 36-37)*

Additionally, Alex reflects on how he developed his skills through supervisory relationships, which helped direct his work:

*[T]hroughout the years, of working with this populations, you learn as you go and if you’re fortunate enough, you have excellent supervisors who can really guide you and prepare you for what to expect, and to intervene and how to be successful in working with this population. (12.2.16; 43-46)*

**Necessary skill sets (individual).** All participants recognized essential counseling skills to work with children with ASD. Thus, the subcategories are means to which the participants felt they could be effective working persons with the diagnosis.

**Assessment.** Seven participants identified it was imperative to assess for co-morbid conditions when working with children diagnosed with ASD. However, there was no consensus on how to assess comorbidity outside of the diagnosis of ASD. Emily and Jean describe how they assesses co-occurring conditions:

*Emily: Talking to the adults in their life... Taking a look at their history and then what symptoms appear to be above and beyond what would be accounted for by an autistic diagnosis. (11.9.16; 192, 197-198)*

*Jean: [B]eing able to say, 'okay, this is what I know about autism and when some of these other symptoms present themselves, a) have you tried everything [most basic strategies and supports] that you know [that work] for autism, and b) when do you decide when it becomes a secondary diagnosis. (11.18.16; 368-371)*

Later during the depth interview, Jean emphasizes getting the “whole picture” of the child to address co-morbid conditions:

*[T]ake your time, build a relationship, don't make assumptions, and gather all of the information... [G]et the whole picture of the kid, you know? When we assess these kids we probably go above and beyond in terms of like what does school look like, what is homework like, did we talk to this person, what do we know about this, how did they deal with this, what types of supports do they need? Just getting the full picture. (11.18.16; 576-577, 580-584)*

**Counseling approach.** Eight of the participants promoted an individualized treatment approach when working with children with ASD. Participants acknowledged there are general themes across ASD, but as Douglas explains:

*I would say every case is unique... [T]hat's why it's a spectrum because of different levels of severity. (10.31.16; 220-225)*

Six participants described the importance of giving the client a voice and collaborating with the client. Jean shares her perspective of working with HFA:

*I also think that making sure that we are being as explicitly clear as possible about our expectations and if it is a really high functioning kid, getting them to buy in and build into creating those expectations. I like a lot of these older kids they get really bogged down by, 'you're controlling my life, you're making the decisions, I'm 20, I wanna have a say in that'... [T]ry to treat them as stereotypical as possible but also delve in the supports that they need for their deficits. (11.18.16; 172-180)*

Participants shared several effective interventions that they deemed essential to know as a counselor to work with the diagnosis (i.e., play therapy, bibliotherapy, art therapy, positive psychology, cognitive behavioral therapy, acceptance commitment therapy).

Furthermore, participants illustrated the importance of having “black and white” treatment and being “very concrete” when working individually with clients. Toni shares her experiences in individual counseling:

*The other thing that was really interesting about the anxiety and depression specifically and working with people with autism was that if that was their main issue, it was not necessarily super helpful to process the roots and causes of those issues... [G]oing through or like understanding a whole lot about family dynamics or early childhood experiences was not necessarily an emphasis I took... They were very concrete, black and white, recommendations that you know, were created collaboratively. (11.23.16; 205-209, 213-214)*

Further, six participants described how group therapy was an effective intervention for ASD. Alex shares how he would encourage and get the group members to communicate to “draw out conversation”:

*I would absolutely say we established motivators for each of the clients so if clients were participating in group, they would earn candy or a snack... It would be reinforcing for them. In the group to facilitate conversation we would [incorporate] their preferred interests to draw out the conversations and then relate it back to whatever the social topic was for that particular group session. (12.2.16; 56-61)*

**Specific “tools.”** Thirteen participants outlined meaningful interventions to use in session. For example, participants discussed the importance of “setting up a consistent routine,” social stories, visual supports, and behavioral strategies as effective interventions to work with children with ASD. Jean shares the value of using reinforcement as a behavioral intervention:

*[H]ow do we constantly praise or reinforce when they are doing their work and then I think the other thing is the motivational piece and I think sometimes it can be taken for granted... [F]or our kids, making sure the reinforcement is meaningful and also making sure that it’s changing with them if it needs to. (11.18.16; 194-199)*

Similarly, Elizabeth and Emily describe their counseling techniques that are effective in session:

*Elizabeth: [I] rely less on that [talk therapy] and more on pictures whether it's drawing, or the PEC system [Picture Exchange Communication System] ... [L]etting them act stuff out... I've done social stories where they kind of write the social story for me and I've written a social story before and said, 'do you think this is accurate for you?' (10.30.16; 119-121)*

*Emily: Setting up a routine, so, people with autism need to have a really consistent routine and they also need to know when they're done with something... I also used behavioral techniques to help move the session along was very helpful. Sometimes, I, again, it depends on the functioning level, sometimes pictures, sometimes words, we'll literally write out a schedule for what we're going to accomplish in session... And literally crossing things off or removing the picture as we go. It decreases tension and I also noticed that it helps with keeping them coming back and not increasing behaviors around therapy sessions. (11.9.16; 134-135, 163-169)*

**Necessary skill sets (family).** All of the participants recognized essential counseling skills to work with families with ASD. Therefore, the subcategories are techniques the participants used so they could be successful working with the family.

**Counseling approach.** Six participants discussed the importance of “partnering with the family” and “allowing them to have an input in the process.” Jean describes her approach to working with the families:

*[P]eople are really quick to blame the family. At the end of the day, by the time the kids get to us, families are just trying to survive... And I think it's always coming from a perspective of understanding and really trying to get at what it was really like for them... Not judging, but working with them. (11.18.16; 529-533)*

In addition, nine participants focused on psychoeducation as a technique to not only use with the parents, but with the siblings as well. Toni and Emily reflect on their work with families and infusing psychoeducation into the session:



*Toni: I worked with a lot of newly diagnosed families, there was a lot of psychoeducation going on um, un-teaching the things that they had learned on Google, or whatever... A lot of helping them process the emotional impact of getting a lifelong diagnosis... [E]xplaining the difficulties that they've had from a different perspective and just acknowledging the frustrations and emotional reactions that come along with the diagnosis. (11.23.16; 250-254, 258-260)*

*Emily: [A] lot of families, they really lack a lot of education around why they're [child with ASD] is doing what they're doing but also, um, what are the capabilities to expect. Because I do have a lot of parents that, as we know, there is no cure for autism but there's still that candle of hope, and a lot of anger and frustration around why this child is acting the way they are, things don't seem to be improving, um, and really helping them understand that progress and dealing with these kids in baby steps. (11.9.16; 227-233)*

Moreover, ten participants supported grief counseling with families and “processing the emotional impact of having a lifelong diagnosis.” Mel and Anna share their work as counselors and facilitating grief work:

*Mel: [What's] been my experience in working with families is, they come in and a lot of times the parents are just so angry and resentful towards this child who's, who just doesn't make any sense to them. (11.2.16; 48-50)*

*Anna: A lot of times it was acceptance... [I did] a lot of work with them to try to help them adjust their expectations because many of the families were still in the process of grieving the expectations you would have of someone that is a more typical child and having them work through the process of accepting what their child's limitations are but also helping them to figure out how to use those, their strengths to help them be happy and find things that would help them to be content with their life. (12.6.16; 75-82)*

**Specific “tools.”** Participants outlined specific tools they used in session with families such as facilitating communication between family members and the child with ASD, adjusting expectations, teaching interventions, and connecting families to resources in the community. Eight participants recognized the importance of teaching families’ interventions that they could use in their home environment, as well as how to respond appropriately to the child with ASD and facilitate a “common language.” Emily reflects on her experience teaching the families interventions to use in the home:

*I also do behavioral training with them [parents] and teach them how to relate to their kid a little bit better but also put in rules and expectations and routines that are going to help their child succeed... [C]onstant structure and routine... And that's not a natural thing for most families and households. It's not an easy way to function... So being able to teach them and work with them to develop that for their home and what's gonna work with their value system. Because if it doesn't fit their value system, they're not likely to keep it up. (11.9.16; 241-250)*

Additionally, eight participants acknowledged the significance of assisting parents in adjusting their expectations to “transforming the system.” Jannell and Alex and describe their experience working with the families and realigning expectations:

*Jannell: Um, a lot of these parents, I have noticed, are very like, they're very rigid about what they do and do not want for their kids. Um so, presenting ideas can be difficult sometimes. And of course the parent knows their kid best, but at the same time we have research to back up these interventions that we're wanting to put into place. So, you have to kind of tread lightly with um, especially with parents that I've been in the program for a significant amount of time without a whole lot of changes. So like a lot of them would be resistant to making changes to the kid's program, kinda like the idea, 'if it's not broke, don't fix it.' But at the same time, yes, their kid is doing okay, but they're not moving forward, they're just kind of stagnant. So trying to get the parents to notice that, but also allowing it to be their idea and allowing them to have a role in the input. (11.22.16; 59-69)*

*Alex: I would say that it [fluid stages of grief] varies from family just because people are different and some people are going to hold onto this belief that their child is capable of much more than what their functional level is... I would say the families that were on the acceptance stage or moving towards there, they were more receptive to having a conversation around what expectations could look like and what progress can look like for their child. (11.18.16; 236-239, 250-252)*

Lastly, six participants recognized gaining access to resources can be difficult for the family, but it is critical for counselors to link families to a “team or community of people.” Mel and Hillary share their experiences connecting families to resources in the community:

*Hillary: Well, I think one [aspect] that is really important in working with families is making sure they don't feel isolated and making sure you connect them with resources. (12.8.16; 98-99)*

*Mel: That's [support group for parents] was so important. I'm trained to empathize with anything but I can't empathize with what she's [parent with a child with ASD] going through like another parent with a child with ASD can empathize. (11.2.16; 291-293)*

## **Action**

Participants described action competencies that mirrored Ratts et al's (2016) operationalized MCC (i.e., MSJCC) to work with children and families with ASD.

Several of the participants described engaging in *social justice advocacy* efforts.

**Social justice advocacy.** Six participants recognized the importance of engaging in social justice advocacy work as a counselor and that “traditional” counseling may fall short in addressing the needs of the population. Simon and Hillary share their experiences of engaging in social justice advocacy endeavors:

*Simon: [T]o evaluate and to try to figure out I guess where some of the boundaries that govern the typical counseling relationship, you know, how to examine those in a way um, I think social workers perhaps would be trained more so than counselors again, to think systematically about how to connect one of these individuals to a job or to a network of friends... But I think if counselors stay entirely within sort of the framework of um, my role is in this relationship [as] a counselor, and we need to drain these periods of time... these 45 to 50 minutes that we spend together and I try to help the individual... That may fall short in some cases... Is there something else that's clinically appropriate that counselors could be doing that goes beyond the office space or something like that for the benefit of their clients? (12.27.16; 300-317)*

*Hillary: And then advocating, particularly at the schools, advocating with the family and with the student and their respective schools. That way they feel like they have somebody on their team because when they couldn't find the words, you're there to help support them and figure out what they need to say. [Me: How did you develop that?] I just did it. Really I just, I think that with this and politics, blah, blah, blah, well you know what, my job is to look after the family and the child. If that means upsetting people, then so be it. But I use counselor skills [and] have intentionality behind it to help support the family and the child. [Me: So counseling isn't about playing it safe?] Absolutely. And if I was comfortable all the time then I really wouldn't help create change. Being uncomfortable is okay. And then, after doing it [advocacy] a couple of times, you think, 'man, I was pretty good, that worked!' (12.8.16; 113-116, 125-134)*

Further, Bobbi recognizes her own privileges and how it is her “responsibility” to use this privilege to benefit her clients:

*I don't think I've ever really been treated with any biases from others in my life but to me, I was raised like because of that [privilege] then I have a responsibility to others you know, so I take that really seriously... [Y]ou're given gifts and abilities and your responsibility is to use those and share those to benefit other people. (11.23.16; 227-230)*

### **Cohesion: Awareness, knowledge, skills, and action**

Participants described the interaction between awareness, knowledge, skills, and action competencies to work with children and families with ASD. A majority of the participants acknowledged that through their experiences (i.e., personal, work, and post-graduate experiences), competencies developed by gaining *exposure* to the diagnosis. Once the participants gained some sort of exposure, the cyclical, developmental process of increasing competence activated as referenced in the ASD Counseling Competencies Developmental model (see Figure 4.1).

**“Exposure.”** By being exposed to ASD and working with families, eight participants shared how this contact increased their confidence. Specifically, Emily and Elizabeth explain how their exposure facilitated their self-assurance in the counseling room:

*Elizabeth: So ever since I worked with him [child with ASD] and I think, ‘okay, well I can work with a nonverbal child dealing with grief, then I can deal with this such and such kid, that ya know is having this behavior or deal with this.’ Like I got over that big hurdle and then I think well, ‘okay I can do this.’ (10.30.16; 73-76)*

*Emily: [S]o I think that's why I don't feel like I was missing anything from grad school because at the same time, I was professionally trained through the [hospital]. They really walk you through what applied behavioral analysis is and what you do with these kids... [H]ow do you teach them, how do you decrease*

*aggression, how do you get them functioning at home more effectively... So they were heavy on the training and there was a right way to do it and a wrong way to do it. (11.9.16; 43-54)*

Furthermore, two participants who teach in counselor education described the importance of gaining exposure and recognized that it is “vital” for student development:

*Toni: I think it's critical is to get exposure... [A]ctual practicum's or fieldwork experiences. That's going to be the best learning tool, I think, that was the best learning tool for me, just being around people with autism and their family members and understanding their dynamic. (11.23.16; 561-566)*

### **Counselor identity**

Participants described their professional orientation and how their counseling identity provided them the framework to counsel children with ASD and their families. A majority of the participants acknowledged that their counseling identity developed during their educational experiences, as well as through their post-graduate experiences. All of the participants shared that *valuing specialization* and defining their role, as a counselor is necessary to work with this ASD. Additionally, participants outlined *basic counseling skills* they used during their session with children with ASD and their families.

**“Value specialization.”** Seven participants distinguished the importance of advocating for the counseling profession, knowing what a counselor can “bring to the table” and “showcasing our strengths as counselors.” Toni, Florence and Anna outline their experiences of advocating for the profession and claiming a counselor identity:

*Toni: [T]here definitely is value in specialization, there is value in defining your discipline and I don't take that lightly. Because I definitely am a counselor, I'm not a behavioral analyst, I'm not a special education teacher. But, tending to review those roles as more different than they are alike, to me does not help with the tension or, really, the ultimate goal of positive treatment outcomes... [I]t is really important to look at our similarities as an opportunity to collaborate, and*

*then, yes, showcase our strengths and show what we [counselors] bring to the table when we're treating people with autism. (11.23.16; 521-530)*

*Florence: We [counselors] are the experts whether we have a ton of training or not... They [families, general education teachers] may not have had anyone else to explain things to them even some minor tips or just like validate, and listen... I think all counselors need to understand that... Don't discredit yourself as the counselor. (12.27.16; 321-327)*

*Anna: I think some of the other disciplines that are involved in the treatment team are more scientific than a counselor per say... [O]ne of the things that happens especially with the behavioral interventions is that everything is very black and white and I think as a counselor you're sort of taught to think in shades of gray... [T]aking on the perspective of the persons or the client versus this, you know, first we do a, then we do b, and then we do c... [I]t definitely is a challenge sometimes to where somebody would focus more so on the behavior and wanna have data, that's not always important. (12.6.16; 149-158)*

Furthermore, Mel describes her struggle of maintaining her identity and feeling conflicted by the mental health system and the “sick, recovery model”:

*[M]y training as an MFT really conflicted with the medical model that is often ingrained in community mental health because I come in and I'm trained to see them family as my client and you can't do that in mental health. You have to diagnose one child, that's the client and anytime you met with the parents, if you want to do marriage counseling, it can only be brief and it has to be related to the child... I can do what I can, but it [medical model] is a very sick model. It's, you come in, you're sick, you get treatment, [and] you get better. And my training as an MFT, teaches me to be must more holistic and much more... We look at cycles, we look at patterns, [and] we look at relational interactions. (11.2.16; 135-139, 157-160)*

**Basic counseling skills.** Eleven participants acknowledged the importance of building rapport with the client, especially children with ASD. Jean and Alex discuss developing a relationship to meet the needs of their clients:

*Jean: I think it was this myth that these kids don't build relationships. It's so the opposite I think. Where they're verbal or not these kids build relationships, they build trust, they depend on people, they know who the people are that are gonna keep coming back and showing up to meet their needs. (11.18.16; 315-318)*

*Alex: [F]or a population that doesn't really have strong social skills um, a lot of interventions in therapy with these clients is relationship based and if they are*

*comfortable around you, then you are more likely to have success and you are more likely to be intervening successfully as well. (12.2.16; 115-118)*

Participants emphasized some general counseling interventions such as therapeutic confrontation, normalizing families' experiences, reframing the problem, and general parenting techniques (i.e., token economies). Moreover, similar to building rapport with child with ASD, it is also important to develop a relationship with the family. Anna highlights how building rapport creates a level of trust and understanding:

*[I]n working with the parents, it was very helpful to be able to develop that rapport and the relationships with the parents to help them understand what specifically the needs of their child were and how we can go about helping them work towards stepping down to a less restrictive setting. (12.6.16; 69-72)*

### **Professional orientation**

Participants described their professional orientation when addressing the needs of the population. A majority of the participants recognized that their professional position developed through their life, educational, and clinical experiences. Twelve of the participants shared a *humanistic perspective* and acknowledged the ability of every human being. Furthermore, participants identified that through their experiences, *meeting them* [client/family] *where they are*, fostering a *strength-based approach*, as well as a *person-first perspective* was essential to be an effective counselor.

**Humanistic perspective.** Twelve participants illustrated engaging in the humanistic tradition such as a person-centered counseling approach (Rogers, 1961). For example, Elizabeth and Hillary share their insight and humanizing their clients:

*Elizabeth: I guess my overriding thought is that they're human, they're children, they're people. You know, they have this diagnosis, their brain works differently. (10.30.16; 330-331)*

*Hillary: What's the most critical? That's pretty easy. That they're human... [S]o listen to them. (12.8.16; 298-300)*

In addition, Simon, Douglas and Mel reflect on Rogers' (1961) person-centered, empathic approach and "not falling victim" to labeling oneself the expert:

*Simon: [P]erhaps I don't think of myself as an expert which allows me to not fall victim to think that I have all the answers. Or perhaps I'd seen utility in not putting individuals into boxes or understanding it through more traditional diagnostic frameworks. (12.27.16; 477-479)*

*Douglas: [A]s a grad student in counseling I remember an instructor saying, 'you may be an expert at a technique but you're not the expert of your client's life, your client is the expert.' So I've taken that as just, um, my approach to everyone that I work with, teach me how to best work with you. Yeah, I may have some skills and some knowledge that I can share but I need to know the best way to work with you and that's really how I approach all my work is that, they're the expert. (10.31.16; 72-75)*

*Mel: [S]pecifically the thing that has stuck with me and the thing that I really help parents or their caregivers is to have an attitude of 'teach me about you.' I'm not gonna make assumptions, you know, I can teach them certain things that may help them be more empathic and understanding... [T]o not project ourselves or expectations onto them, to just have the attitude of just relax and let this child teach us about them... I came in [to the counseling session] with an attitude of this isn't my area of expertise so you and your child are going to teach me what it's like to be in your shoes, teach me what it is like to parent a child with autism spectrum diagnosis. You and I, mom and dad or whomever, we're going to rely on your child to teach us about them in their experience. And I think that that, maybe having that attitude was something that helped. (11.2.16; 29-35, 223-227)*

John discusses the importance of empathy, but conceptualizes the term differently than Rogers' (1961) definition of empathy:

*John: [T]he given answer counselors are always going to talk about is empathy... Empathy still counts, but I'm not sure it's at the top of the ladder like it is for other people. So I would translate it into 'kind patience.' (3.9.16; 248-251)*

**Strength-based approach.** Nine participants described recognizing the child and family's "capabilities" and fostering a strength-based approach. Anna and Mel explain their approach to counseling and focusing on the assets of the child with ASD:



*Anna: [B]eing able to look at a situation and try to identify the strengths and the positive components of the situation can be helpful when working with this population. A lot of time you might see progress but it might take a really long time and it might be very small and that can feel really frustrating if all you're focused on is the big picture instead of using patience and looking at the bright side or the baby steps that the child might've been able to make. That in itself is a success. (12.6.16; 232-237)*

*Mel: [T]hey [families] come in and a lot of times the parents are just angry and resentful towards this kid who's, who just doesn't make sense to them. There's so many "why's" ... And being able to help those parents see, what their kids are really good at. (11.2.16; 48-52)*

**“Meeting them [client/family] where they are.”** Eleven of the participants expressed connecting with clients and families by “meeting them where they are” versus where they believed they should be. Anna, Kaitlin and Jean explain their approach to joining with clients:

*Anna: [Y]ou had to change things in order to meet your clients where they were at and put things on a level to help them understand. (12.6.16; 45-47)*

*Kaitlin: [K]nowing that they [children with autism] can learn. They're just as capable but it's again, it's finding those different avenues and strategies that, you know, are a benefit for them... but it's just like figuring out those little things and like you said, meeting them where they're at and just remembering they're a student with autism but they're not autistic. (10.21.16; 370-371, 375-377)*

*Jean: [T]he biggest thing for me was, so looking at the individual and trying to understand what they benefited from, as well as where their challenges were. (11.18.16; 52-54)*

**“Person-first perspective.”** Six participants identified children with ASD are first and foremost people who have individual abilities, interests, and needs. Douglas and Kaitlin reflect on respecting a person-first perspective:

*Douglas: I think that's [person-first perspective] my mentality... [T]he environments that I've been placed in. As a person of color, um, I've always kind of been taught as a person first and it doesn't matter what they're dealing with or what they look like or um, that's just the mentality I've always had. (10.31.16; 72-75)*

*Kaitlin: You have to know, this child and their disability, but you just have to know this child, it's not just their disability. (10.21.16; 356-357)*

### **Personal characteristics**

Participants described how their individual characteristics promoted their work with children diagnosed with ASD and their families. A majority of the participants recognized that their personal attributes stemmed from their life and work experiences. Participants' illustrated six personal qualities that included *perseverance*, being *creative*, *flexible*, and *patient* are fundamental to working with the diagnosis. Furthermore, participants identified that through their experiences, *taking on the initiative*, as well as recognizing their experience as *fulfilling* was essential to be an effective counselor.

**“Perseverance.”** Eight participants described taking on the challenge of working with the diagnosis and going outside of their “comfort zone.” Anthony reflects on the importance of not giving up when working with ASD:

*You're going to fail and you're not going to feel like you're not making progress but um, you have keep pushing through... [D]on't give up, I mean, just don't give up, keep going, keep doing what you're doing to help the client. (12.2.16; 306-310)*

**“Creative.”** Eight participants shared their experiences of thinking “outside of the box” and being creative when working with ASD. Anna and Simon reflect on the importance of creativity:

*Anna: [Y]ou had to be creative and think outside the box in order to come up with new ways to help kids with developmental disabilities to be able to learn the skills to help them be more successful. (12.6.16; 34-36)*

*Simon: So again, I think that being in a situation where it would call, probably calls upon the counselor to think, again outside of the box and to think about how to both connect this individual or connect families to have a greater impact. (12.27.16; 353-356)*

**“Flexible.”** Six participants described how crucial it was to be flexible within the counseling session when working with children with ASD and their families. Elizabeth and Emily recognize the significance of flexibility:

*Elizabeth: [B]e flexible and meet them where they are. Um, ‘cause if you have the idea that, I’m a counselor so I talk with them, you’re not gonna get anywhere. (10.30.16; 312-313)*

*Emily: Um, and thinking on the fly too because I can’t tell you how many sessions I’ve sat down with a client and my great, wonderful plan that I had underway in my brain, ready to go, was a complete bust and you just have to switch it up at that moment because you are also managing behaviors with this diagnosis. (11.9.16; 127-130)*

**“Patience.”** Six participants acknowledged patience as an “extremely” important aspect to maintain as a counselor. Douglas, Kaitlin, Jannell and Alex share their perspective of sustaining patience throughout the counseling process:

*Douglas: [F]or me it [having a brother with ASD] taught me patience with working [with] autism... I’ve become very patient because obviously having had that personal experience with it, um it’s allowed me to not be as frustrated with slow progress or challenges in progress. (10.31.16; 46-49)*

*Kaitlin: [T]he patience piece, I think is huge because when they do get it, it’s one of the most beautiful things ever and like I said, I have a kid that gives me hugs who didn’t like to be touched. So, things like that, that makes it better when you see those strides. (10.21.16; 429-432)*

*Jannell: [T]his isn’t something that education teaches you but, patience is really important. You have to be patient with these kids. You have to be patient with these families. The diagnosis is inherently hard. It’s hard on everybody that is involved. It’s hard for the kiddos experiencing it and can’t express themselves or the parents who don’t understand and don’t know what do or don’t have the right resources to get what they need. Um, and just you know, having patience and perseverance is really important. (11.22.16; 47-48)*

*Alex: I would say that I developed patience through my work experience more than I’m a naturally patient person. I would say that being around the population and having the client-centered approach, which I was taught in my graduate program were the keys to develop the patience and understanding is required to really be affective with working with ASD... [G]oing through the counseling program, you hear and you are kind of guided on the principle of being patient*

*with the clients and all that, but I think that really develops once you start practicing. (12.2.16; 159-165)*

**“Taking on initiative.”** Thirteen participants recounted being resourceful by: (a) researching the diagnosis on the Internet; (b) joining listservs; (c) purchasing books such as autobiographies; (d) engaging in active “problem solving”; and (e) connecting with their mentors to increase their effectiveness with the diagnosis. Kaitlin and Jean reflect on taking the initiative to increase their effectiveness working with ASD:

*Kaitlin: I’m one of those people that takes initiative and just goes [and] explore[s] on my own if I feel like there isn’t enough... I wish it [ASD] was talked about more [in counseling program], but then again, you don’t know what you don’t know until you’re there. (10.21.16; 157-160)*

*Jean: I can’t stop thinking about ways to improve it [work with clients]. So I’m always in the box of what haven’t we done, what can we do, what else do we need to try versus giving up. And I don’t know, I love spending time with the kids. I like problem solving, I like thinking about things we haven’t tried. When somebody comes up with a new idea, I really wanna be involved in implementing and following through. (11.18.16; 455-460)*

**“Fulfilling” experience.** Six participants described counseling children across the spectrum and their families as a rewarding experience, but also recognizing it can be “a lot of work.” Toni and Florence share their experiences working with the diagnosis:

*Toni: [W]orking with people with autism can be so professionally and personally fulfilling that when people are able to get exposure or if they’re able to specialize in this, it can be a life changing career track. And I hope that the opportunity is awarded to more and more people you know; this gap is bridged a little bit more between people with disabilities or people with autism and connecting them to counseling professionals. (11.23.16; 585-589)*

*Florence: They are fantastic and enjoyable and they will be frustrating and um, they’re great clients and you’re going to be challenged in lots of different ways but, but don’t be afraid. (12.27.16; 309-311)*

## Summary

In order to answer the two research questions: *How do counselors describe their experiences counseling children and families with ASD*; and *How do counselors describe their development of clinical competence working with children and families with ASD*, analysis procedures using Moustakas' (1994) phenomenological model were applied to approximately 9 hours and 45 minutes of audio-interview data or 283 pages of verbatim interview transcription data. The data emerged through depth, semi-structured interviews with 15 participants who identified as having a range of expertise working with children with ASD and their families. The aforementioned findings of the research process are discussed in Chapter 5.

## CHAPTER 5

### DISCUSSION

The leading counseling organizations have recognized principles, standards, and specific counseling competencies favored to work in the field (ACA, 2014; CACREP, 2016). Though, defining counselor competence is difficult because it is a complex, multidimensional construct (Sommers-Flanagan, 2015). Counselor competence is defined as having the skills, professional dispositions, behaviors (Swank & Lambie, 2012) and judgment (Bernard & Goodyear, 2014) that contribute to positive client outcomes. Even though the profession has implemented safeguards to ensure competent counselors in the field, AMCD called for explicit MCC (Sue et al., 1982). MCC requires counselors to develop *awareness*, *knowledge* and *skill* to be considered competent to meet the needs of culturally diverse clients (Chao, 2013; Collins & Arthur, 2010; Constantine, 2001; Constantine, 2002; Ivers et al., 2016; Ivers & Villalba, 2015; Johnson & Williams, 2015; Quinn, 2012; Rogers-Sirin et al., 2015; Sue et al., 1992). Logically, disability competence has fallen under MCC. However, counseling and related fields identified how persons with disabilities have their own distinct characteristics and the multicultural framework may oversimplify their circumstances (Artman & Daniels, 2010; Chan et al., 2003; Gilson & DePoy, 2002; Gourdine & Sanders, 2002; Kemp & Mallinckrodt, 1996; McClean, 2008; Strike et al., 2004; Weiss et al., 2010). Furthermore, the developmental disability, ASD, is the fifth leading diagnosis in children (CDC, 2013) and yet, the

counseling profession has not recognized the competencies needed to treat this diagnosis.

The scholarship generated over the past three decades provided a foundation to the empirical inquiry of ASD counseling competencies development. Many unanswered questions remained at the beginning of the study. First, no study to date had investigated specific ASD counseling competencies necessary to treat children with ASD and their families, as well as how these competencies develop overtime. Further, no study exclusively utilized professional counselors across disciplines (i.e., LPCs, LMFTs, and CSCs) to establish competencies for the profession. Second, most of the studies from the counseling field explored self-perceived counselors-in-training and professional counselors' MCC development (e.g., Barden & Greene, 2015; Chao, 2013; Constantine, 2001; Constantine, 2002; Cook et al., 2015; Holcomb-McCoy & Myers, 1999; Ivers et al., 2016; Ivers & Villalba, 2015; Johnson & Williams, 2015). However, Roger-Siren et al. (2015) explored immigrant college students' perception of their therapists' cultural competence. Even though this current study is based on the SPC of participants, it is an important foundation to establish standards for the profession before exploring client perceived competence of the counselor. Finally, researchers in the speech and language pathology and social work professions have examined ASD competence. Therefore, the purpose of the study was to explore the experiences of counselors who identified as having expertise in the area of ASD and how through their experiences, they developed clinical competencies working with children diagnosed with ASD and their families. Using Moustakas' (1994) phenomenological model, I analyzed the data to answer the following research questions:

RQ1: How do counselors describe their experiences counseling children diagnosed with ASD and their families?

RQ2: How do counselors describe their development of clinical competence working with children diagnosed with ASD and their families?

The study sought to answer the two research questions by engaging in depth interviews with a sample of self-identified skilled counselors in the diagnosis and treatment of ASD. I recruited counselors to participate in the study through purposeful and snowball sampling techniques. Open, semi-structured interviews with 15 participants yielded approximately 9 hours and 45 minutes of audio-interview data and 847 horizontalized statements of data. Participants had a mean of eight years of professional experience and held a Master's (87%), or doctorate (13%) degree. Participants worked in various settings including the K through 12 school system (20%), private practice (7%), behavioral program (7%), primary care (7%), academia (7%), community mental health (27%), and residential (27%).

### **Summary of results: Experiences and development of clinical competence**

Research question one focused on *how counselors' described their experiences counseling children and families with ASD*. Analysis revealed participants' life experiences and post-graduate experiences impacted their effectiveness working with ASD. Sporadically, participants described how their graduate training experiences influenced their ability to work with the diagnosis. Thus, by sharing their experiences, research question two was addressed: *How do counselors describe their development of clinical competence working with children and families with ASD?* Through their experiences, participants described the developmental components of MCC such as



*awareness, knowledge, and skills* competencies. Upon completing data analysis, there were several overarching categories that that fell outside of the MCC conceptual framework. Specifically, by gaining *exposure*, the fluid relationship between the MCC competencies of awareness, knowledge, and skills built their expertise to work with the diagnosis. Additionally, analysis illustrated participants engaged in *action* competencies, as well as describing a *counseling identity, professional orientation, and personal characteristics* to meet the needs of the child with ASD and their family.

## **Interpretation of Findings**

### **Emergent Core Categories**

#### **Awareness**

One of the three main areas of MCC, awareness, emerged as an overarching category. The results coincided with the theoretical definition of awareness, where Sue et al. (1992) describes a “culturally skilled counselor is one who is actively in the process of becoming aware of his or her own assumptions about human behavior, values, biases, preconceived notions, personal limitation, and so forth” (p. 481). Furthermore, Ratts et al. (2016) operationalized MCC to include social justice advocacy. The authors believed counselors must possess certain attitudes and beliefs to practice counseling and commit to advocacy from a multicultural and social justice framework. Results demonstrated that through participants’ life and post-graduate experiences, they developed awareness competencies. However, participants shared how their graduate experiences did not assist with challenging their attitudes and biases. Further analysis illustrated several subcategories that emerged from the data. Participants discussed how their life

experiences provided them an “*insider status*” of the phenomenon and through *personal exposure* and *family upbringing*; this enhanced their expertise working with the diagnosis. In addition, through their post-graduate experiences, participants recognized the importance of *realigning their expectations* as a counselor and acknowledging their *scope of practice*. Lastly, participants described their *assumptions and biases* working with the diagnosis and how they challenged their assumptions and biases. Though, several participants claimed their own personal experiences prevented personal biases and assumptions when working with this population.

**“Insiders status.”** The results of the current study suggest participants who identified as having a child, family member with a disability, as well as being on the autism spectrum themselves, could “relate” and connect with the families and children with ASD on a different level than someone who did not have these experiences. However, results illustrated even when the participant had a personal experience with disability or ASD; this did not make the individual an expert. Thus, participants believed the *client and family are the experts* of their worldview (Ratts et al., 2016). The findings are congruent with Holcomb-McCoy and Myers’ (1999) study where they investigated the relationship between selected demographics and MCC. They found race/ethnicity to be the only statistically significant demographic that influenced knowledge, racial identity, awareness, and skills factors associated with MCC.

**Personal exposure.** Participants shared how exposure to a disability (e.g., family member, family friend, classmates, and fellow church attendees) promoted a higher tolerance for acceptance and connection to persons with a disability (Werner, 2011). Early exposure to persons with disabilities is similar to Strike et al’s (2004) findings

where the more experienced group (i.e., personal experience, training, work experience, etc.) scored significantly higher than the not experienced group on all three competencies of awareness, knowledge, and skills. Findings coincide with Dinecola and Lemieux (2015) study as well, which found self-efficacy increased when respondents ( $n = 59$ , 60.8%) had personal experiences with persons with ASD.

**Family upbringing.** Participants described how their family upbringing fostered acceptance and sensitivity to working with this population. Further, participants shared how their family upbringing taught them life lessons to not force people into boxes. Two of the five participants noted their cultural upbringing promoted their awareness competencies development and fostered their approach to counseling. Akin to what Constantine (2001) found, race/ethnicity contributed significantly to MCC, specifically, ratings for African-American and Latino-American trainees.

**“Balanced pushing and accepting”: Realign expectations.** When discussing awareness competencies, participants identified the importance of realigning their expectations as a counselor, as well as finding a balance between pushing and accepting the client with ASD for who they are.

**Scope of practice.** When detecting if there is a liability risk, counselors are told to “perform only those actions that are included within the state scope of practice act, satisfy the licensure requirements, adhere to the standard of care, reflect professional ethical guidelines and comply with employer policies, procedures, and protocols (Healthcare Providers Service Organization [HPSO], 2014, p. 68). Based on the results, participants acknowledged the importance of recognizing when they met their limits as a counselor

and referred out to professionals in the field of ASD. However, one participant explicitly shared her frustration of not having community resources and because of this, added differential diagnoses so she could see the client and the family.

**Assumptions and biases.** Like Werner's (2011) study, participants explicitly shared their assumptions and biases regarding children with ASD and their families. The most frequent response as it related to participants' attitudes was parents of children with ASD were challenging to work with, as well as working with child was "intense" and initially outside of their comfort zone. Correspondingly, Thomas et al. (2011) found counselors were third overall when measuring service professionals' positive perceptions of disabilities (physical and mental). The results revealed participants were not only open to sharing their biases entering the field, but also explained how they challenged their biases. For example, participants described recognizing how parenting a child with ASD can be difficult; therefore, did not see the parents as challenging, but acknowledged parents are functioning the best they can with their circumstances. Lastly, some participants claimed harboring no assumptions or biases due to their personal experiences (i.e., family and cultural upbringing), but recognized this did not make them an expert.

## **Knowledge**

Another core category that emerged from the data was the MCC construct of knowledge. The results coincided with Sue et al. (1992) definition of knowledge, where a "culturally skilled counselor is one who actively attempts to understand the worldviews of his or her culturally different client without negative judgments" (p. 481). Furthermore, Ratts et al. (2016) who operationalized MCC defined knowledge as

possessing relevant multicultural and social justice theories and constructs as necessary to guide multicultural and social justice competence. Results demonstrated that through participants' life and post-graduate experiences, they developed knowledge competencies. However, all of the participants except for two addressed how their *graduate training experiences* had little to no impact on their foundational knowledge to work with ASD. Further analysis illustrated several subcategories that emerged from the data. Participants discussed how their experiences familiarized them with *applied behavioral analysis* as an effective intervention for ASD, as well as engaging in a *multidisciplinary approach*. Participants shared the importance of having *mentors* and connecting with colleagues as a way to increase one's expertise as a counselor. Finally, all of the participants shared *necessary knowledge sets* for both individual and family counseling.

**Graduate training experiences.** More than half of the participants explicitly discussed how their graduate training did not provide them the knowledge to work with ASD. Pulling from the SLP literature, researchers also found a significant portion of respondents' reported receiving little to no information about ASD during their graduate-level coursework (Casella & Colella, 2004; Dinecola & Lemieuz, 2015; Plumb & Plexico, 2013) and indicated they would have benefited from further training and coursework (Schwartz & Drager, 2008). Ivers et al. (2016) found that completion of the multicultural course increased participant's knowledge, but did not indicate an association between multicultural awareness. Therefore, similar to the two participants who shared how their counseling professor infused ASD into the curriculum, this

experience influenced their foundational knowledge to work with children across the autism spectrum and their families.

**Applied behavioral analysis (ABA).** Like Sheperis et al. (2014), participants recognized the importance of understanding tenets of ABA, as well as using ABA as a fundamental roadmap to guide treatment. Some of these individual interventions include differential reinforcement, extinction, fading, prompting, and antecedent-based interventions (Sheperis et al., 2014).

**“Multidisciplinary approach.”** There is a current push for an interdisciplinary, comprehensive approach to increase the health and well-being of children with ASD and their families (Bennett et al., 2012; Feather, 2016; VanBergeijk, Klin, & Volkmar, 2008). Plumb and Plexico (2013) investigated the extent in which SLPs’ collaborated with school personnel and found the majority of respondents’ reported collaborating weekly since a most of their clients’ utilized a combination of therapy approaches. Participants also described the importance of engaging in a collaborative approach with professionals in and outside of the counseling profession. These disciplines include BCBAs, speech-language pathologists, special education teachers, psychiatrists, psychologists, social workers, and occupational therapists. Many of the participants recognized the multidisciplinary approach as best practice and recognized it provided them a different perspective to the treatment process. Furthermore, Feather (2016) outlined the importance of consistency and communication across treatment settings to enhance treatment outcomes.

**“Mentors.”** Results demonstrated almost all of the participants reflected on the significance of mentors and how this impacted their work counseling children with ASD and their families. Participants described that engaging in mentorship enabled them to see the whole person and conceptualize the client. Counseling scholarship has supported mentorship and validated it increases professional identity (Christenson, 2009).

**Necessary knowledge sets (individual).** Results indicated participants believed understanding the diagnostic criteria, symptoms, needs and developmental nature of ASD was a significant part of providing best practice services (APA, 2013). When reflecting on the child’s needs, participants also identified recognizing triggers of the client was also important. Further, results specified that understanding counseling children with ASD and their families can be exhausting, but also rewarding as well. Lastly, participants shared that traditional counseling approaches may not always be appropriate when working with this diagnosis.

**Necessary knowledge sets (family).** Over half of the participants recognized approaching their work from a family systems perspective to enable them to see the bigger picture and transform the system. Similarly, Feather (2016) detailed the counselor’s role and best practice, where counselors must be mindful of the child’s needs and engaging in a family-centered approach. By understanding the needs of the family system, participants suggested setting realistic goals that fit the family dynamic, as well as collaboratively creating these goals with the family. By addressing the family from a systems perspective, participants also emphasized the importance of understanding the range of emotions families may experience regarding the child with ASD. There are several research studies that outline the effects a child diagnosed with ASD will have on

the family, parents, and the parents' marriage (e.g., Neely, Amatea, Echevarria-Doan, & Tannen, 2012; Ramisch, 2012; Ramisch, Timm, Hock, & Topor, 2013). Studies illustrate that parents of children with ASD experience significant levels of emotional distress and consistently express feelings of isolation, compared to parents of children diagnosed with other disorders (e.g., Down syndrome or developmental delay; Layne, 2007). Depending on the severity of the child's symptoms and behaviors, evidence confirms it is a strong predictor for parental stress (Johnson, 2012), as well as higher rates for alcoholism within the family (Layne, 2007). Results from the current study imply parents of children with ASD may experience grief, which mirrors previous research. Neeley et al. (2012) outlined the challenges to adjusting to ASD when parents are expecting to raise a neurotypical child. These adjustments may include coping with their own feelings of disappointment, guilt, and emotional pain (Neely et al., 2012).

## **Skill**

A core category that emerged from the data was the MCC concept of skill. The results corresponded with Sue et al. (1992) definition of skill, where a "culturally skilled counselor is one who is in the process of actively developing and practicing appropriate, relevant, and sensitive intervention strategies and skills in working with his or her culturally different clients" (p. 481). Moreover, Ratts et al. (2016) who operationalized MCC defined skill as possessing relevant multicultural and social justice informed attitudes, beliefs, and knowledge provides the background for counselors to develop cultural and change-fostering, skill-based interventions. Results revealed that through participants' life and post-graduate experiences, they developed the skills competency. More specifically, participants described building their expertise through *trial and error*



and all of the participants shared *necessary skill sets* for both individual and family counseling. Additional analysis confirmed several subcategories that emerged from the data under the necessary skill sets. For individual counseling, participants outlined skills that related to *assessment*, *counseling approach*, and lastly, *specific tools* to work with children with ASD. When working with the families with ASD, participants shared their *counseling approach* and *specific tools* to work with the family system.

**“Trial and error.”** Results indicated well over half of the participants developed their skills through firsthand experience and actually doing the counseling work. The participants engaged in a form and the problem solving where they approach treatment using insight (i.e., intuitive nature) and theory (i.e., established understanding that explains and predicts the phenomena) when working with the diagnosis. Furthermore, supervision experiences also enhanced their work with the child and family with ASD.

**Necessary skill sets (individual).** From an individual counseling approach, participants recognized essential counseling skills to work with children with ASD. First, participants identified assessing for co-morbid conditions as a fundamental skill; however, there was no consensus as to how to assess for comorbidity outside of the ASD diagnosis. Children with ASD typically present with co-occurring conditions such as intellectual disability, stereotypical and self-stimulatory behaviors, insomnia, seizure disorder/epilepsy, Tourette syndrome, tic disorders, gastrointestinal problems, anxiety, depression, obsessive-compulsive disorder, attention deficit hyperactivity disorder, and self-injurious behaviors (Feather, 2016). These diagnoses further intensify the complex disposition and challenges associated with ASD (Simpson, 2008).

Second, participants promoted a systematically individualized treatment approach, as well as encouraging clients with ASD to be a part of the counseling process (Layne, 2007). Because autism is a spectrum, treatment should be individualized to meet the child's needs and concentrate on various areas of development (Bennett et al., 2012; Shapiris et al., 2014). There were numerous counseling approaches that participants believed were helpful to work with the diagnosis (i.e., play therapy, bibliotherapy, art therapy, positive psychology, cognitive behavioral therapy, and acceptance commitment therapy), but acknowledged that being as concrete as possible was key. Moreover, similar to Laugeson, Frankel, Gantman, Dillon, and Mogil's (2012) research, participants approved group counseling as an effective intervention with ASD; however, children with ASD need to be screened to ensure they get the most out of the intervention.

Lastly, participants recognized specific tools that are helpful in session with children with ASD. For example, participants discussed the importance of "setting up a consistent routine," social stories, visual supports, and behavioral strategies as effective interventions to work with the diagnosis. Like Feather's (2016) conceptual model for counselors, the author outlined several individual interventions that coincide with the findings of this study. Feather summarized during individual counseling, counselors can implement social stories and PECS to provide a *structured* and *predictable* schedule that can alleviate anxiety and negative behaviors, while also keeping the child on task. Further, Feather outlined positive reinforcement as an effective intervention to extinguish maladaptive behaviors.

**Necessary skill sets (family).** From a systems perspective, all of the participants recognized necessary counseling skills needed to work with families with ASD.

Subcategories from the findings revealed a counseling approach and specific tools counselors could use in session. Participants shared their approach to counseling the families, which included a collaborative partnership and allowing the family to have input in the process (Murray, Ackerman-Spain, Williams, & Ryley, 2011; Neely et al., 2012). Results revealed that participants were able to focus on providing psychoeducation to the family, as well as the siblings regarding the child with ASD. Murray et al. (2011) addressed the importance of providing psychoeducation to the client with ASD and the family and cited this knowledge as empowering. Further, participants were able to address the emotional impact of having a lifelong diagnosis and facilitating grief work with the families (Neeley et al., 2012).

Over half of the participants shared how they were proactive in teaching families' interventions they could use in the home, while also considering the value system of the family (Neely et al., 2012). Additionally, results indicated participants were facilitative in adjusting the parents' expectations and focusing the family on the child's strengths versus their deficits (Bennett et al., 2012). Lastly, participants recognized it was important to connect families to a team and community of people to increase positive treatment outcomes. As Feather (2016) asserted, typically when treating a client with ASD, the child will most likely or should be involved with various specialists (e.g., occupational therapist, physical therapist, pharmaceutical management, BCBA specialist, intervention specialist, etc.). If families are not involved with these disciplines, counselors should refer families to specialists to improve treatment outcomes (Feather, 2016).

## Action

Participants described the action competency that mirrored Ratts et al. (2016) operationalized MCC (i.e., MSJCC) to work with children with ASD and their families. Several of the participants described engaging in *social justice advocacy* efforts during their post-graduate experiences. Cook et al. (2015) defined social justice advocacy as “a process of acknowledging systematic societal inequities and oppression while acting responsibility to eliminate the systematic oppression in the forms of racism, sexism, heterosexism, classism, and other biases in clinical practice both on individual and distributive levels” (p.126).

**Social justice advocacy.** Results coincide with the fourth developmental competency, action, is which Ratts et al. (2016) believes generates the highest influence on counseling interventions with clients. Overall, results indicated action behaviors influenced the development and expertise of participants. Participants described how counselors need to examine the boundaries that govern the counseling relationship and thus, engaging in social justice advocacy to work with this diagnosis. Again, this is consistent with Ratts et al. (2016) MSJCC framework, where the authors supported a multilevel approach that includes individual counseling, as well as social justice advocacy outside the counseling room. The authors termed ‘socioeconomical model’ as a framework for counselors to determine if “interventions should occur at the intrapersonal, interpersonal, institutional, community, public policy, and international/global levels” (p. 34). Furthermore, Grothaus et al. (2012) outlined advocacy and fostering a critical consciousness, facilitating the development of positive identity, and encouraging social action (i.e., empowerment) when working with diverse clientele.

## **Cohesion: Awareness, knowledge, skills, and action**

Participants described the interaction between awareness, knowledge, skills, and action to work with children with ASD and their families. The findings validated the tripartite model first introduced by Sue et al (1982) and recognized MCC is a multifaceted process. MCC is conceptualized as counselors' *awareness* of personal attitudes and beliefs, *knowledge* of different cultural groups, and ability to use appropriate counseling *skills* when working with a diverse range of cultural groups (Sue et al., 1992). Further, Ratts et al (2016) distinguished *action* behaviors as a counselor the most important competency to address the needs of clients. A majority of the participants acknowledged that through their experiences (i.e., personal, work, and post-graduate experiences), competencies developed by gaining *exposure* to the diagnosis.

**Exposure.** Over half of the participants recognized that having contact with the diagnosis and working with families increased their confidence. Similar to Strike et al's (2004) findings, the respondents reported they had some type of experience related to disability (i.e., personal experience, training, work experience, etc.) and the experienced group scored significantly higher than the non-experienced group on all three competencies (i.e., awareness, knowledge, and skills). Two participants who are counselor educators explained that gaining exposure was vital to student development, which was similar to findings in previous studies. Dinecola and Lemieux (2015) found self-efficacy increased when social work students actually had the experience working with persons with ASD. Similarly, Werner (2011) identified the behavioral characteristic of having previous contact and experience in the field eased helping professionals into the field of ASD.

## Counselor identity

The leading accrediting organization, CACREP (2016) stresses standards that support a professional counseling identity that coincides with the counseling curriculum. CACREP (2016) endorses eight common core areas that represent the foundational knowledge required of all entry-level counseling graduates. Participants described their professional orientation, which they attributed to their graduate training. Further, based on their graduate training experiences, their counselor identity provided them the basic structure to counsel children with ASD and their families. Results validate a majority of the participants acknowledged that their counselor identity developed during their educational experiences, as well as through their post-graduate experiences. All of the participants shared that *valuing specialization* and defining their role, as a counselor is necessary to work with this ASD. Additionally, participants outlined *basic counseling skills* for individual counseling and family counseling.

**“Value specialization.”** Results distinguish the importance of advocating for the counseling profession, understanding the strengths of the profession and claiming a counselor identity. Sommers-Flanagan’s (2015) eight evidence-based relationship (EBP) principles to increase positive client outcomes coincide with counselor identity. Sommers-Flanagan emphasized the importance of integrating EBP and encouraged counselors to “embrace evidenced-based relationships as a core component of counselor competency” (p. 106). He argued the eight relational factors (i.e., congruence and genuineness, the working alliance, unconditional positive regard or radical acceptance, empathic understanding, rupture and repair, managing countertransference, implementing in- and out-of-session procedures, and progress monitoring) align with the counselors’

professional identity and are easier to embrace as a profession versus the complex standards addressed by leading organizations in the field. Furthermore, participants described their struggle to maintain their identity and feeling conflicted by sick, recovery model engrained in the mental health system. There is no origin or cure for ASD (Feather, 2016); thus, one cannot “recover” from ASD. Related research (Artman & Daniels, 2010; Gilson & DePoy, 2002) outlined how the psychology field frequently pulls from the medical, deficiency model, but instead should conceptualize clients from the social model of disability, which focuses on power, resources, and unequal access.

**Basic counseling skills.** A majority of the participants acknowledged the importance of building rapport with the client, especially children with ASD. Further, participants also highlighted building rapport with the family as well. Parallel to Sommers-Flanagan’s (2015) theoretical article, he asserted the significance of fostering a relational approach with clients, while also instilling EBPs. Relational and strength-based methods have also been validated across diverse populations and are an effective treatment (Sharf, 2008). In addition to building a relationship with the family, findings illustrated some general counseling interventions such as therapeutic confrontation, normalizing families’ experiences, reframing the problem, and general parenting techniques (i.e., token economies) that participants used with the families in session.

### **Professional orientation**

An examination of the counselor development literature suggests that the processes of developing an integrated professional identity converge with the processes of aligning with a theoretical orientation (Shallcross, 2013). Participants described their

professional orientation when addressing the needs of the population. A majority of the participants recognized that their professional position developed through their life, educational, and clinical experiences. Over half of the participants shared a *humanistic perspective* and acknowledged the ability of every human being. Furthermore, participants identified that through their experiences, *meeting them* [client/family] *where they are*, fostering a *strength-based approach*, as well as a *person-first perspective* was essential to be an effective counselor.

**Humanistic perspective.** Fostering a person-centered approach was validated by the results and has been cited as an effective tradition across diagnoses and diverse clientele (Quinn, 2012). Quinn stated *empathy* is an important attribute because counselors are more likely to embrace cultural diversity and “accept the relationship as is— ambiguous and complex” (p. 214). Similar to the results of the study, participants reflected that having an empathic approach assisted them with not falling victim to labeling oneself as an expert (Rogers-Siren et al., 2015; Shallcross, 2012); however, one participant did state they would characterize empathy as “kind patience” when working with children with ASD and their families. Participants further reflected on the importance of identifying the capabilities and strengths of the child and family versus the deficits of the individual (Bennett et al., 2012; Grothaus, 2012). Moreover, participants identified joining the client and family by meeting them where they are and engaging in a collaborative conversation was facilitative (Murphy, 2015). Lastly, findings indicated participants were cognizant of maintaining a person-first perspective and recognizing the individuals’ abilities, interests, and needs (Burchardt, 2004).



## Personal characteristics

Participants described how their individual characteristics promoted their work with children with ASD and their families (Werner, 2011). A majority of the participants recognized that their personal attributes stemmed from their life and work experiences. Participants' illustrated personal qualities that included *perseverance*, being *creative*, *flexible*, and *patient* are fundamental to working with this diagnosis. Furthermore, participants identified that through their experiences, *taking on the initiative*, as well as recognizing their experience as *fulfilling* was essential to be an effective counselor.

Results indicated that participants persevered by going outside of their comfort zone when working with the diagnosis and did not give up when faced with challenges treating the child and family with ASD. Participants described the importance of being creative and thinking outside the box when working with ASD (Bennett et al., 2012). Participants also shared how crucial it is to be flexible within the counseling session when working with the diagnosis. Furthermore, participants recognized patience was an extremely important personal characteristic to maintain when working with ASD (Rogers-Siren et al., 2015; Werner, 2011). Moreover, almost all of the participants were resourceful when engaging in their own research that increased their knowledge to work with the diagnosis due to the limited information they received during their graduate training. Lastly, participants reflected that their work across the spectrum was rewarding, but also recognized it can "exhausting" (Werner, 2011).

## **Implications and Social Change**

Counselors must be deemed competent and demonstrate the ability to provide adequate counseling services (ACA, 2014, Standard C.2.a.). Concerning specialty areas, ACA (2014) clearly affirms, “Counselors practice in specialty areas new to them after appropriate education, training, and supervised experience. While developing new skills in specialty areas, counselors take steps to ensure the competence of their work and to protect others from possible harm” (Standard C.2.b.). ASD is a diagnosis that is on the rise (CDC, 2015a) and counselors must be prepared and deemed competent to work with the diagnosis (Feather, 2016). Therefore, the purpose of this study was to generate overarching competencies to treat children diagnosed with ASD and their families. By exploring counselors’ experiences through a phenomenological framework, participants described their development of clinical competence to treat this diagnosis, as well as address the needs of the family.

The implications for the findings reviewed above have many practical applications, which will subsequently be explored. Conversely, one general implication is that most of the participants did not address ASD during their graduate training and learned on the job through trial and error. While almost all of the participants hailed mentors as a significant source to foster their expertise, life and post-graduate experiences were critical to their development as well. Initially, I believed practicing through trial and error was not best-practice. However, most of the participants learned through trial and error, but acknowledged protective factors (i.e., mentors, multidisciplinary team, strong professional identity, and life experiences) to ensure they were practicing at the highest ethical manner.

Further, most of the participants shared on how their professional orientation, humanism, was helpful when attending to the needs of the child with ASD and their family. Participants shared the importance of understanding the tenets of ABA since historically it is the leading treatment for ASD (Sheperis et al., 2014); however, the skill sets the participants brought to their counseling session was starkly different than strict behavioral interventions. Finally, these participants specifically called on the field to provide more training opportunities regarding ASD and identifying effective counseling interventions. Successively, I share recommendations for action to address ASD in counselor education, clinical practice, and future studies on this topic.

### **Recommendations for Action**

#### **Counselor Education**

Participants acknowledged how counselor education must address the needs of children with ASD and their families in the counseling curriculum. Similar to previous studies, participants advocated for: (a) clinical contact, (b) infusing ASD content into curriculum, (c) guest lectures by persons in the counseling field and/or persons with ASD, or (d) a standalone course dedicated to ASD content (Burnett, 2014; Weiss et al., 2010).

**Multicultural and social justice counseling competence.** All participants described developing their MSJCC through personal, work, and post-graduate experiences. All but two participants shared how their graduate training assisted them with their MSJCC development. Therefore, pedagogical strategies such as increasing multicultural and social justice advocacy content throughout the counseling curriculum

must be addressed to enhance students' MSJCC (e.g., Barden & Greene, 2015; Chao, 2013; Constantine, 2001; Constantine, 2002; Cook et al., 2015; Dinecola & Lemieux, 2015; Holcomb-McCoy & Myers, 1999; Ratts et al., 2016; Rogers-Siren et al., 2015). More specifically, participants shared a standalone class (Burnett, 2014) or infusing disability and ASD content into the curriculum would provide counselors-in-training opportunities to address their attitudes and beliefs, knowledge, micro and method interventions (Gourdine & Sanders, 2002), and action experiences to increase self-efficacy (Barden & Greene, 2015; Dinecola & Lemieux, 2015) and MSJCC (Ratts et al., 2016). Previous research has demonstrated even a small amount of training and clinical contact with persons with disabilities such as ASD, is associated with less bias, appropriate case conceptualization, and treatment planning (Burnett, 2014; Cascella & Colella, 2004; Dincola & Lemieux, 2015; Kemp & Mallinckrodt, 1996; Plumb & Plexico, 2013; Strike et al., 2004; Schwartz & Drager, 2008; Weiss et al., 2010; Werner, 2011). Moreover, Werner (2011) found students reported a lack of information contributed to their avoidance of working with ASD. Therefore, providing students with MSJCC is critical to demystify working with ASD and increase competence overall. What is also crucial is offering students clinical contact to children with ASD and their families, which has shown to increase competence (Weiss et al., 2010).

**Exposure.** Research has confirmed students typically have minimal clinical preparation, as well as hands on experience with persons with ASD (Cascella & Colella, 2004; Schwartz and Drager, 2008). Participants echoed previous findings, but shared how their personal exposure to the diagnosis provided them a higher tolerance for acceptance. Specifically, researchers examined the amount of exposure participants had to persons

with disabilities, as well as ASD and found that when participants were exposed to the diagnosis, this increased their overall competence (Burnett, 2014; Strike et al., 2004, Werner, 2011). Additionally, participants in the current study advocated for counselor education to expose students to ASD, which they believed was vital for their development, as well as increasing confidence. Therefore, counselor educators can contribute to positive attitudinal development through increasing one's knowledge, training, and contact with persons with ASD (Werner, 2011).

**Counselor identity.** Having a solid professional identity allowed participants to go into their work settings feeling self-assured and capable of clearly articulating who they are and what they do as a counselor. By valuing their specialization and acknowledging what the counseling profession can bring to the table, this was instrumental in providing adequate services to the children across the autism spectrum and their families. Leaders in the field have recognized professional identity development is a process that requires strong mentors who are willing to invest their time and energy not only in teaching but also in leadership and advocacy (Shallcross, 2013). Overall, clients benefit when counselors are competent in their counseling skills, as well as confident in their role as a counselor (Shallcross, 2013). Hence, participants also recognized the basic counseling skills taught in their graduate training was facilitative in connecting and providing meaningful services to the child with ASD and their family. Participants emphasized some general counseling interventions such as rapport building, therapeutic confrontation, normalizing families' experiences, reframing the problem, and general parenting techniques (i.e., token economies). Therefore, counselor educators can continue to foster professional identity development and assist counselors-in-training in

recognizing their strengths as a professional counselor to meet the needs of children with ASD and their families.

**Supervision.** Several of the participants shared how their supervision experiences enhanced and guided their work with ASD. Conversely, participants shared they learned through trial and error and expanded their knowledge through their own initiative; thus, they did not pull on their supervisors to assist them in developing expertise. Parallel to studies investigating MCC, themes yielded the benefit of integrating a targeted supervision curriculum in counseling programs to build student's self-awareness and social justice orientation to increase self-confidence (Cook et al., 2015). Furthermore, the availability of support within and outside the workplace was considered necessary to increase confidence working with ASD (Werner, 2011). Therefore, based on previous research and the current findings, supervisors can play a critical role in enhancing practice with ASD.

### **Clinical practice**

The suggested competencies evolved through the findings of this study. The ASD Counseling Competencies Development model (see Figure 4.1) is geared toward professionally trained counselors. Counselors are in an ideal position to help develop interventions that address the complex needs of children with ASD and their families. Many of the participants in the study developed their expertise working with the diagnosis through clinical practice, exposure, mentorship, fostering a professional orientation, and personal characteristics.

**Exposure.** A majority of the participants reported they did not receive any sort of educational or clinical training when working with children diagnosed with ASD and their families. All stated they learned on the job and through trial and error experiences. Throughout their trial and error experiences, they built their awareness, knowledge, skills, and action competencies to address the needs of the population, as well as the participants' own attitudes and beliefs towards the diagnosis. Even though this is not best practice for the field, all of the participants were reflective on how this was a necessary step to build competence and address the needs of this population. As Kaitlin eloquently stated, "I'm one of those people that takes initiative and just goes [and] explores on my own if I feel like there isn't enough... I wish it [ASD] was talked about more [in counseling program], but then again, you don't know what you don't know until you're there" (10.21.16; 157160). Nevertheless, the participants were mindful of their practice and constantly building their competencies by connecting with mentors in the field.

**Mentorship.** Mentorship in the counseling profession has been defined as "a matter of working with somebody to help them become more grounded in the practice of their profession... [and] help[s] that person with his or her professional development" (Christenson, 2009, p. 1). However, many of the mentors were outside of the counseling profession (i.e., ASD family members, speech language pathologists, special education teachers, behaviorists, intervention specialists), but still built their counseling competencies to work effectively with the diagnosis. Therefore, it is not only important for counselor educators to promote mentorship relationships in the field, but for the counselor themselves to reach out and connect with others who can possibly enhance effectiveness.

**Professional orientation.** Half of the participants described their professional orientation as humanistic, person-centered approach to address the needs of this population. To be an effective counselor, participants believed it was essential to meet the client and families where they are, foster a strength-based approach, as well as a person-first perspective. Similar to Sommers-Flanagan's (2015) evidence-based relationship factors and practical approaches that contribute to counselor competence and positive client outcomes, he identified eight evidence-based relationship factors that included: (a) congruence and genuineness; (b) the working alliance; (c) unconditional positive regard or radical acceptance; (d) empathic understanding; (e) rupture and repair; (f) managing countertransference; (g) implementing in- and out-of-session procedures; and (h) progress monitoring. All eight of these relationship factors was touched on throughout the interviews and emerged from the findings.

**Personal characteristics.** Participants shared how their personal characteristics and attributes assisted them in the counseling room with children with ASD and their families. Participants illustrated personal qualities that included perseverance, creativity, flexibility, and patience were fundamental to working with the diagnosis. Furthermore, participants identified that through their experiences, taking on the initiative, as well as recognizing their experience as fulfilling was essential to be an effective counselor.

*Counseling Today* (Shallcross, 2012) published an article on what makes a truly great counselor. Leaders from the field of counselor education shared their perspective. Many of them echoed the importance of being flexible and the ability as a counselor to adapt. Further, leaders recognized counselors should be patient and match the client's pace in



session. Furthermore, creativity, courage, compassion for their clients, and forming meaningful connections was also addressed and coincided with the results of the study.

### **Recommendation for Further Study**

As noted in Chapter 3, I attempted to validate the categories and subcategories through a focus group modality. Unfortunately, due to unforeseen circumstances from several of the participants, I was unable to complete the focus group. Therefore, I recommend future research studies triangulate the categories and subcategories through engaging in a focus group, as well as document analysis. Several of the participants reported they have presented on ASD at the local, state, and national level regarding effective interventions for both the individual and family. Thus, engaging in a purposeful sampling method to recruit potential participants with a background in research and presenting in this area is recommended. Furthermore, continuing to recruit a diverse sample of professional counselors (i.e., LPCs, CSCs, and LMFTs) is also advised.

The present study offers a model of ASD Counseling Competencies Development to work with children diagnosed with ASD and their families. Participants in the study developed their expertise to work with the diagnosis through a cyclical process, where one aspect of the model could not develop without the other. The model is a significant contribution to the counseling field because of its implications for understanding counselor competency development, as well as implications for the profession. What emerged from the data was that counselor competency development is more complex than just developing MCC. Participants' personal and clinical experiences impacted their effectiveness and by gaining exposure to persons with ASD, ignited MSJCC

development. Outside of the MSJCC framework, participants' shared how their personal attributes, counselor identity, and professional orientation enhanced their work with clients.

While the categories are positioned by the data for which they emerged, we do not yet know which parts of the model are the strongest predictors for competency development. Therefore, I suggest that future research studies examine which factors are the strongest predictors to ASD counselor competencies development such as, personal characteristics, one's professional orientation, counselor identity, or personal experiences that situate the individual to be the most effective counselor with the diagnosis.

Finally, one major limitation for the study is that data is based on participants' SPC in counseling children with ASD and their families. As a result, I recommend future research studies address this limitation by triangulating the data. For example, recruiting clients to provide their perceived effectiveness of the counselor through informal and formal assessments (McLeod, 1992). Further, appraisal from a supervisor as an external judge of competence is also recommended (McLeod, 1992).

### **Limitations**

Although the study attempts to provide a comprehensive list of competencies in counseling children with ASD and their families, I want to acknowledge this study has limitations in its scope. One limitation of qualitative research is the data is filtered through the researcher's lens and personal subjectivity (Denzin & Lincoln, 2013). I was mindful to note my ontological and epistemological assumptions, as well as bracket my position to the phenomenon (Creswell, 2014); however, my personal approach to

counseling clients on the autism spectrum could have influenced the findings. While this is a limitation for phenomenological research, my subjectivity to the research can also be a significant contribution to the analysis process because of my clinical background of treating the diagnosis. A second limitation to engaging in phenomenological inquiry is that participants' may have difficulty bracketing their own experiences and assumptions (Hays & Wood, 2011). At times throughout the interview process, participants struggled to verbalize their expertise, which may have affected what was shared and what was not discussed. Another limitation is the data is based on the SPC of counselors. SPC is defined as a self-evaluation of one's effectiveness or capability in a specific context (Boekaerts, 1991). The data cannot be confirmed by the clients receiving counseling services or through feedback from supervisors and/or peers (McLeod, 1992). A fourth limitation of the dissertation is the sample of participants have varying years of experience; thus, intricacies and diverse levels of development many not be detected. Lastly, the data was regionally bound and the findings are not applicable across all disciplines in the field of counseling.

### **Conclusion and Researcher Reflections**

The CDC (2015b) has recognized ASD as an important public health concern and must be addressed by the counseling profession. The pervasiveness of ASD is steadily increasing, which mirrors the unanswered questions of families. Traditionally, ASD has a profound impact on families, as well as on the individuals themselves. With the diagnosis on the rise (CDC, 2015a), many professional counselors will be faced with the joys and challenges of working with children diagnosed with ASD and their families. Based on my interactions with the participants and findings from the study, participants reflected on

their experiences and how through these experiences, developed expertise in the area of ASD. In retrospect, I was amazed by the participants' extraordinary commitment to their work and willingness to engage with the population even if they received minimal training and supervision around the diagnosis. I marveled at how the participants constantly questioned what they were doing and why, being brutally honest with themselves about their work and its outcomes. They were always requesting feedback from their clients, colleagues, and mentors, begging for the most honest assessments about what was working and what was not. Counseling children on the autism spectrum and their families can be demanding (Werner, 2011); however, the participants shared how fulfilling their work was and acknowledged the strengths of the children with ASD and their families. These individuals humanized their clients by accepting their abilities, interests and needs. I realized early on as I listened to the experiences of the participants that counselor education did not make them experts in the field of ASD, but nurtured the counselor that was already within them. Counselors can play a dynamic role in treating ASD and promoting greater life satisfaction for the child and the family; the participants believed it and grabbed a piece of the puzzle.

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## APPENDIX A – RECRUITMENT EMAIL

Study title: A Phenomenological Investigation of Counselor Competencies in Working with Children Diagnosed with Autism Spectrum Disorder and Their Families

Dear Counselor,

I am conducting a study at the University of South Carolina (USC) on counselor competency development working with children and families with autism spectrum disorder (ASD). The purpose of this study is to explore the self-perceived expertise and experiences of counselors who treat children with ASD and their families. Currently, no particular competencies exist treating children with ASD in the counseling literature and I would like your experience as a counselor to be showcased.

**The criteria for participants includes:**

**(a) hold a license as a licensed professional counselor (LPC), licensed marriage family therapist (LMFT) or are a school counselor in the K through 12 school system; and**

**(b) counsel children diagnosed with ASD and/or their families.**

*If you are interested in participating in the study, please reply to [kfeather@email.sc.edu](mailto:kfeather@email.sc.edu) with your name and contact information to schedule an interview.*

The interview will be audio taped as part of this study and will last approximately 45 to 60 minutes. You may be asked follow-up interview questions after the initial meeting.

Participants will be given a \$20.00 gift card for participating in the study.

Please feel free to contact me with any questions. You may also reach my advisor, Dr. Joshua Gold, at [josgold@mailbox.sc.edu](mailto:josgold@mailbox.sc.edu).

I thank you for your willingness to help us in this research.

Most kind regards,  
Katherine Feather

Investigator Contact Information:  
Katherine A. Feather, M.A., LPC  
[kfeather@email.sc.edu](mailto:kfeather@email.sc.edu)  
[440-241-2550](tel:440-241-2550)  
Doctoral Candidate  
Counselor Education and Supervision

University of South Carolina

Advisor: Dr. Joshua Gold [josgold@mailbox.sc.edu](mailto:josgold@mailbox.sc.edu)

Note: This study has received approval from USC's institutional review board. Participation is confidential. Study information will be kept in a secure location at USC. Upon study completion, recordings will be destroyed. The results of the study may be published or presented at professional meetings, but your identity will not be revealed. Although you probably will not benefit directly from participating in this study, we hope that this study will identify specific competencies that will prove essential to scholars, counselor educators, and supervisors to enhance counselor training and standards.

## APPENDIX B – CONSENT FORM

### A Phenomenological Investigation of Counselor Competencies in Working with Children

#### Diagnosed with Autism Spectrum Disorder and Their Families

My name is Katherine Feather and I am conducting this study for my doctoral dissertation. I am a Ph.D. candidate at the University of South Carolina (USC). I am conducting this study in order to gain a deeper understanding of the self-perceived competencies and experiences of counselors in the field when working with children and families with autism spectrum disorder (ASD). In addition, how you, as the counselor, have built your competencies overtime to effectively treat this diagnosis. This information may prove valuable to the field of counselor education, supervision, and service providers who work with children with ASD and their families. You are being asked to participate because you have acknowledged you counsel children diagnosed with ASD and their families. You do not have to answer any question or questions you do not want to answer. This interview is being recorded, so that I will be able to accurately reflect on the information you share during the interview. The interview will take approximately 45 to 60 minutes. You will have an opportunity to review the transcript for accuracy and completeness. You will receive the transcript of the interview via email. You may contact me regarding questions about this research or the Office of Research Compliance manager at USC regarding your right as a participant. Assuming this interview protocol is acceptable to you, let us move to the interview questions.

## APPENDIX C – PRE-INTERVIEW QUESTIONNAIRE

Please do not write your name on this form. The information will allow the researcher to provide an accurate description of the sample. The form will be stored and kept confidential.

Demographic form:

1. Sex (circle one).
  - a. Female
  - b. Male
  - c. Other (please specify). \_\_\_\_\_
2. Ethnicity (circle all that apply).
  - a. African American, Black
  - b. American Indian, Native American
  - c. Asian, Pacific Islander
  - d. Caucasian, White
  - e. Hispanic, Latino, Chicano
  - f. Other (please specify). \_\_\_\_\_
3. Age \_\_\_\_\_
4. Please circle your highest degree earned.
  - a. M.A.
  - b. M.S.
  - c. Ed.S.
  - d. Ed.D.
  - e. Ph.D.
  - f. Other (please specify). \_\_\_\_\_
5. I am a (circle all that apply):
  - a. Licensed professional counselor (LPC)
  - b. Licensed marriage family therapist (LMFT)
  - c. School counselor
  - d. Other (please specify). \_\_\_\_\_
6. I have \_\_\_\_\_ year(s) of experience counseling clients with autism spectrum disorder (ASD).

7. In what type of setting are you working as a counselor?  
\_\_\_\_\_
8. My experience with children with ASD includes the following (circle all that apply):
- a. A member of my family or close acquaintance is diagnosed with ASD
  - b. ASD was discussed during my academic training
  - c. ASD was addressed in seminars and/or workshops I attended
  - d. I have recent work experience involving children with ASD (within the past 5 years)
  - e. I have past work experience involving children with ASD (5 or more years ago).
  - f. Other (please specify).  
\_\_\_\_\_
9. What pseudonym would you like to go by? \_\_\_\_\_
10. 10. Would you be interested in participating in a focus group? Yes      No



## APPENDIX D – INTERVIEW GUIDE

1. How did you come to work with ASD?
2. How, if at all, did your educational training contribute to your expertise working with ASD?
  - What were some of the subjects discussed?
  - What specific classes addressed ASD?
  - What would you have liked to learn?
3. a) Tell me about your post-graduate experiences counseling children and families with ASD.
  - How can your place of employment support you in building your expertise working with children with ASD and their families?
    - i. Probes: workshops, professional training
4. How, if at all, did your life experience(s) develop your expertise working with ASD?
5. If you feel comfortable sharing, did you ever experience certain assumptions or biases towards children and families with ASD and if so, how did you work through that?
  - i. Probes: Influenced attitudes, values, self-awareness, attitudes, understanding, familiarity, recognition, and realization
6. Is there anything else you deem critical to know as a counselor working with children with ASD and their families?
  - i. Probe: essential

## APPENDIX E – HORIZONS

### **Florence:**

*In vivo and structural coding*

Educational training: No educational training (outside of DSM)

Framework: Internship experiences built her confidence to see ASD as an LPC

- build curriculum for children with ASD
- understanding visuals
- Play therapy
- Lego groups

Post graduate experiences:

Trial and error

“Figuring it out on my own” self-reliant?

No best-course of treatment

Social skills interventions

“Being very concrete”

Co-morbidity

Assisted with transition

Assisted with behaviors (i.e., melt downs)

“I could have done so much more”—reading and researching dx

Bibliotherapy

Online research

Talking with colleagues

Personalize treatment

Individualized

Collaborated with client

Creative

*Personality:* “My enjoyment of my own quiky-ness and finding that in others [clients]”

Rejoicing in their quirks

Professional identity—Counselors having a passion, understanding and wanting to help client

Strength-based approach

“Make it up as I go” (treatment)

Created individualized interventions

Realign expectations as a counselor

Build rapport

Understanding their needs

Not a lot offered in ASD (school and workshops)

Self-reliant- Confidence to do it on he own

Flexible

*Families:* psychoeducation, teaching them interventions in the home, getting them to understand their child

Help kids “navigate the world”

Can’t “fix them”

Meeting the client where they are

Skills and knowledge to address client's needs

Celebrating quirks

Solid rapport

Assisting with transition to new counselor and how to have healthy relationships with others

Still thinking about the case and where client is now

DSM 5 has made it more "difficult" because you have to "tease out a lot more"

Treated MH dx first

If ASD was first, get baseline functioning and then help them coping to manage everyday life

"Incredibly difficult population"

Constantly questioning: "Will it [counseling] improve anything? Will it change anything?"

Will my efforts have any impact? Are any of the interventions worth doing? Are people [families, teachers, school personnel] going to take your advice and listen?"—Grappling with how effective is counseling?

Such a difficult diagnosis, "doesn't feel competent"

Supervisor: new counselors struggle with dx and can be hard on themselves

- Must be up for the challenge to work with this dx
- build their confidence
- reminding supervisees they have to use tools from their graduate training, now how can they use them with this dx

- Not willing to label herself as an expert.

Life experiences: she and brother may be on the spectrum (has sx of it)

Hyper aware of dx now: We [society] see everything through that lens now... typical developmental development

Counselor education must address this dx and infuse it into the curriculum

Critical: “They are fantastic and enjoyable and they will be frustrating... you’re going to be challenged as a counselor in lots of different ways, but don’t be afraid” – Take risks. This population is rewarding to work with. Don’t assume as a counselor you can’t do this.

“We are the experts whether we have a ton a training or not... They may not have not had anyone else to explain it in a way, provide minor tips, validate, and listen” Baseline knowledge for counseling? We are experts, we can be helpful, we can explain in a way families and school can understand, and we have the skills and framework as a counselor to do good work with this population. --- *Don’t “discredit” yourself as a counselor.* 60

**Anna:**

*In vivo and structural coding*

Educational Training: “Educational training contributed very little”

Post-graduate experiences:

Learned through experience and support from co-workers from different educational backgrounds

Residential program: Bx goals, interventions to help them express their needs, increase independence

Prompted to work with ASD from friend and it “sounded very interesting”—Perked her clinical interest?

Find enduring qualities of the client with ASD

Big learning experience

Enjoyed working with the population

Traditional counseling: can't always implement with this population

Had to be “creative” and “thinking outside the box” because you can't always implement what you learned from training program

Worked with LFA—because of this used a lot of skills of empathy and active listening (“applicable”)

“Meet the clients where they are”

- understanding the child's needs and development

Person-centered approach

Increased knowledge by: Meeting with people, shadowing, and reading on her own

Read books about sx and dx, as well as books that were written by persons with ASD

Skills: Empathy and looking at data to “form hypotheses”

Family work: Build rapport with families, increase their understanding of the needs of their child, “helping families with acceptance,” “adjust their expectations,” grieve not rearing a typical child, accepting child, and identify the child and family strengths.

Intake—information gathering, working with the families/support the decision process (for a higher level of care) and their expectations

- family work can be very challenging (counseling skills can be tested)
- residential: interventions can be paradoxical for the family
- Opportunity to professional growth
- A lot of confrontation

- *Meet the family where they are and understand their reality* (learned this in school, but became an “important component” in treatment)
- No best course of treatment and gaining access to resources is difficult

Supervisor: Provide support (bc dx was challenging and very slow prognosis), validate their feelings and concerns, educate

Treatment team: vital to the treatment of ASD

All come from different disciplines

Helped “see different aspects of the whole person” and what the disciplines focused on and conceptualized the client

As a person of the treatment team focused on feelings and emotions of the client

Holistic approach

Counselors perspective had to be advocated for in treatment team

Other disciplines were very scientific (black/white thinking), while counseling are “taught to think in shades of grey.” Objective versus subjective

- Taking on the perspective of the client versus the client must do A, B, C, and D
- Counselor can bring balance bc it is not always bx driven

Important to understand components of ABA, especially reinforcement.

Must understand what motivates them so they are compliant

Not every counselor is made up to work with this dx – Personality to work with dx

- Takes an interest and desire to work with this dx
- Counselors who are more “cognitive,” process issues, and need feedback would maybe have a hard time with this dx (might not be the “best fit”)

- “innate” working with this population comes naturally

Stayed because “they were able to find things they really enjoyed about the kids”—Look outside the maladaptive box

- enjoyed seeing progress
- developing relationships with the clients
- See the positives

Life experiences: Learning to have patience

- Look at a situation and identify positive aspects and strengths
  - progress can be slow and minimal, but baby steps with this population is

so important and to celebrate this

Strength-based approach

- Being open-minded
- Learned to look at a situation objectively and not rely on one intervention
- Trying new things and being creative
- Flexible

Bias/Assumptions:

High SES will have a better understanding of interventions and helping the child;

however, most parents are completely lost

Critical:

“Still need to develop rapport and build a relationship with the client” 56

**John:**

*In vivo and structural coding*



### Post-graduate experiences

“Happenstance” working with the dx (working at the University) and at the pediatrician office

Others aware of the dx at the University

“Being hands on with folks and trying to think through things”- best course of treatment, particular interventions

Built knowledge through his access on the online listserv

Sought out more training after masters on working with kids

Seeking out information to work with ASD (Center for Disability Resources) –

Resourceful?

Developed his own resources for children with ASD

Line of clinical work is “informed by faith”

- wants to help “empower” people to be able to “function better”
- Faith is an “undertone” and his understanding keeps deepening that God can reveal himself in anything. Persons with disabilities is an “aspect of the image of God.”

More training is needed to work with the dx: PRT and PCIT (would like to be trained in)

- how organizations can support clinicians

John has worked across the spectrum

Consulting is important – person he consults with has a child with ASD

- receive direct, fast feedback
- Reaching out to experts [consultants], as well as sitting back and listening to others and how they would work with ASD (intellectual discussions)

- Weigh in from different perspectives

Important to know your “limits” as a counselor

#### Educational experiences

Professor who taught treatment of childhood disorders class (infused it into the curriculum)

- professor had personal [child with ASD] and clinical experiences with ASD

Participant made a conscious effort to learn in graduate school and work with family of children with “special needs” – wanted to specialize in this

Would randomly read literature on ASD

Diagnostic course touched on it

“I don’t think there’s a lot there”

Teacher’s clinical competencies were specifically working with ASD

#### Life Experiences:

Grew up with a kid in the neighborhood who had a disability- sparked his curiosity.

Thinking back, believes he would have benefited from social skills training, etc.

Niece was born pre-mature

“Insider’s status” with working with the special needs community because he has a child with a disability

Personal experiences impacted his line of clinical work and focus in school

#### Critical:

1. “Empathy still counts, but would translate it to kind patience”
2. The level of information he received in graduate school
3. Must have an understanding of behavioral analysis (especially with LFA)

4. “Tinker objects” in office—keep their hands busy
5. Having an understanding of social stories
6. Be willing to play the expert to others (i.e., normalize what is going on to others) – increasing other’s awareness 37

**Kaitlin:**

*In vivo and structural coding*

Educational experiences:

Undergrad—introduced to learning disabilities

Grad program discussed: making accommodations, doing guidance lessons, working one on one with ASD, professors open to discussing cases and providing recommendations

- discussions came up in class – random
- Peer had a background as a special education teacher and she became a “resource”

Wouldn’t say “ASD was discussed in depth” in graduate school

Kaitlin did her own research when it was not discussed – PROACTIVE

DSM class given an assignment where they were given sx and had to dx and give rationale

Techniques class: IEPs, 504 accommodations, special education, ASD

- wished she would have learned more about 504 plans, more “in depth” about ASD; however, sometimes it’s good to be naïve and get the experience working with the dx

No case-by-case examples and interventions tied to it

Program provided her the “tools” (basic counseling skills, knowledge), but didn’t prepare her to walk in a classroom with ASD and know what to do

Doesn’t feel competent to work with LFA—out of scope of practice

Internship: “Exposure” ... Increased her knowledge and skills more through the experience (sensory issues, not wanting to make eye contact, communication issues, and articulate feelings)

- exposure to different sx and how to work with varying issues in individual and group work
- Creative: getting the child engaged through play and working with partner
- Meeting the client where they are, but pushing them to be part of the group
- “Keeping that safe space, but expanding the bubble”
- Mindful of sx and knowing their triggers

#### Life experiences:

Grew up (“raised around”) with a child with ASD (Mom’s best friend)—“first exposure”

- explained how he was different

#### Post-Graduate experiences:

Collaborated with the ASD teacher at school (“picked her brain,” “resource,” “model,” “mentor”)

- learned about: social stories, sensory bins--- incorporated her own sand bin because of conversation she had with ASD teacher
- specific interventions to work with kids (card on table as a reminder, etc.)
- watched her interactions with students and getting them engaged (“observing”)

- Knows how to motivate students and meet them where they are
- If she has any questions, she can go ask her... open to mentoring her

Still sees building competencies, sees her work as a “learning process”

Aware she does not want to stigmatize the kids

Meeting the child where they are

Person-centered approach

Must be willing to be vulnerable and ask questions

Personality: Line 157-158 “I’m one of those people who takes initiative and just go explore on my own when I feel like it isn’t enough”

- genuine
- cares and makes the child feel important

Important to have a relationship with people in the school so you can get referrals

Intentional about building relationships

Constantly engaging

Create a safe environment

Counseling is on students’ terms

Having a presence in the school

Setting the tone at the beginning of the year who she is and what she is there for (i.e., school counselor versus guidance counselor)

Being available

Personalized work in school: knowing everyone’s name

Doesn’t feel comfortable working with LFA

Life experiences:

Always known she wanted to be in the helping profession

Cultural upbringing, always taking care of someone

“Higher tolerance for acceptance”—babysitting child with ASD

- how to work around aggressive, maladaptive bx
- coming up with “alternative strategies,” problem solving
- learning to be flexible when something does not work and did before

Parents did a good job explaining the acceptance part

Only saw people for people and did not “point out labels”

Person-first ... and “work together”

Softball: had to learn how to “balance” pitcher and different personalities and get a positive working relationship

#### Assumptions/biases:

No, but there are instances where she may have a reaction

#### Critical:

Have the appreciate what makes them special

Working with ASD is “frustratingly rewarding” – must maintain composure

- Rewarding working with dx and seeing progress is “one of the most beautiful things ever”

Person-first perspective: They are “capable”

“Meeting them where they are”

Understands what *motivates* them, but also gives them a voice

Humanist perspective

Family work: educating siblings on ASD

All counselors must be aware of ASD and how to work with it in their school setting.

Needs to be integrated into graduate work

“Patience piece is huge” 70

**Elizabeth:**

*In vivo and structural coding*

Educational Training:

ASD was not addressed during educational training

Looking back, realized how naïve she was and knowing you need experience working with this dx

“You need someone that has some experience and knows what they are doing” to assist with treatment of child

Life experiences:

Wife works USC Center for Disability resources--- Wife is a resource, readily available if she has questions (built “knowledge”)

Post-graduate experiences:

“on-the-job training”

Special education teacher assisted her in building her knowledge and skills to work with student

Grief counseling

“clicked” that she could work with this dx and use counseling interventions to do it—

changed her approach to working with ASD

Took on challenge of working with dx

Collaborated with special education teachers to give her interventions that could assist with the counseling (i.e., PECS)

Special education teacher would help with interpretation/ “translating” (LFA) “mentor”

- always willing to work with me
- open to working with the school counselor (respected what counselors can bring to the classroom)

Working with LFA built her confidence... “got over that big hurdle, thought, ‘ok, I can do this’”

Proactive reaching out to teachers and ask what works with the student

Had to find other means of tapping into emotions/feelings (drawing, reading, act stuff out)

Used visuals

Must be comfortable using other interventions and cannot rely on talk therapy

Aware it is important to get their input

Social stories—special education teacher “model” [ed] how to make SS

Personality: She believes she has “mild ASD”—empathize, “relate a little”

- “I do not want any child, no matter what their diagnosis or his/her abilities to not be able to get help if they need it”—“biggest thing”

Understands her scope of practice (“I have limits”)—proactive and resource out if needed

Does not work with the behavioral issues—others in the school will do this

Open to suggestions

Willing to work on a multidisciplinary team

Available and intentional to meet with everyone in the school



Reaches out to parents

Assumptions/biases:

Didn't think working with ASD was a big deal

“Not being able to speak is not the same as not having anything to say”

- try to think of non-verbal children this way
- challenged herself

Must engage in advocacy and injustices

Person-first framework

Person-centered approach (being aware of the child's needs and providing them appropriate accommodations)

Critical:

Flexibility

“Meeting them where they are”

If you have the idea that ‘I’m a counselor so I talk to them’, you’re not going to get anywhere

Be open to collaborating

Mentors have been very important in teaching her skills and interventions

Humanist perspective: “They’re human” 44

**Douglas:**

*In vivo and structural coding*

Educational experiences:

“I don’t believe that it did. I think it familiarized me with sx but that’s as far as it really went.”

DSM class

Life experiences:

Younger brother diagnosed with ASD (“personal experience”)

Reflecting on what interventions were helpful to use with brother

Had to talk about because he sees it as “normal”—“my brother”

- Person-first “mentality”
- As a “person of color,” was taught this... “Doesn’t matter what they’re dealing with or what they look like” (educators and parents taught him this)

Having his brother taught him “patience”

Learned to realign expectations through this and not become so frustrated with the slow progress

Post-graduate experiences:

Focused on working on family interventions

- patience
- counseling difficult if you do not have “buy in” from the parents of bx that were too severe to work with in counseling
- families come looking for answers
- problem solving on how to manage behaviors
- skills: “general parenting techniques”- token economies
- probe families on what they’re doing to manage ASD
- learned from schools that specialize in managing sx (help “guide his work”)

- open to learn from them and referring out (reciprocal process?), as well as receiving feedback on his work
  - Overall approach to everyone he works with (learned in school): you may be the expert on techniques, but you are not the expert on your client's life
- observed it is important for family members to have a “team of people” around them supporting them with the dx
  - learning resources in the community and connecting families

Professional training has been very limited

Believe ABA is very important to learn and implement in session

#### Assumptions/Biases:

“No because of the personal experience he had.”

- having the challenges of having someone in your family and navigating through things... increases patience” HOWEVER, doesn't make me an expert working with ASD. All he can do is try to understand where they are coming from. Person-centered?

#### Critical:

“every case is unique”

“Be flexible about expectations”

Flexibility 29

#### **Jannell:**

*In vivo and structural coding*

### Educational experiences:

Master's in MH did not increase expertise, but BCBA coursework did (conjunction).

- talked about autism “in general” but nothing that was gone into “in depth”

Coming from a family systems background—allowed her to “see the bigger picture”

(treat the entire family unit)

BCBA: “Very scientific education”

Helped her write stronger programs for ASD

How to recognize behaviors, use data

### Life Experiences:

ABA therapist before going back to school for BCBA

Worked as a lead and line therapist with ASD

Fulfilling/rewarding work (liked seeing progress) and wanted to learn more

Cousin with LFA and “created an additional motivation to learn more”

- saw how the dx consumed the family, however, family worked hard to make sure the dx was not “consuming” the family and that the sibling was not forgotten about

### Post-graduate experiences:

Case management (HFA): writing behavior plans and behavior programs for ASD

Skill building: socialization, being in the community

Managing “some” behaviors

Having the BCBA was really beneficial to writing bx plans, but not necessary to have as a counselor

Working through co-morbidity: Identifying both dx and know the treatments for both and combine treatments together

## Family work (LMFT)

Assess the family situation and how best to implement interventions—Understanding family dynamics

Awareness of the difficulties of parenting a child with ASD

Being helpful in a positive way

Trying not to “step on their toes,” “tread lightly”

May come up against resistance

Important to understand the evidence-based practices to work with ASD

Push so child does not become “stagnant”

Giving parents a voice (“allowing them to have a role and input in the process”)

Challenging working with families and getting them to “let go” of the caretaker role (“identity”)

Individually:

“Exhausting”: Hardest thing is working on something over and over again and not seeing progress and then all of a sudden there is progress and wipes frustrations away

Navigating burnout: taking a break or shifting roles

Skills:

Go into the field thinking “Ok, we’re just gonna sit and talk to people,” but has learned to observe and be quiet, look for non-verbal cues from these kids, for any bx, SIBS

- because communicating their needs is difficult at times
- realigning expectations

Meet the child where they are

Creative

Mentor: BCBA- recognized her passion with this dx, knowledge she shared was valuable, consultation, observing

Assumptions/Biases:

LFA: child can't engage in counseling, but once she built a relationship, the child's personality came through... More than just a child with ASD

Some parents are really "hyper involved" and seeing their kid grow, others just see counselor as a "babysitter"

Critical:

Line 247: "This isn't something that education teaches you, but patience is really important"

Having patience with the child and the family

Perseverance

Strong understanding of the DSM

Having the clinical knowledge

Competence: Knowing how to talk to families

Competence: Knowing how to work with the kids 45

**Mel:**

*In vivo and structural coding*

Educational experiences:

Professor had personal (son with HFA, and suspected he had ASD) and clinical experiences (started a treatment facility in Kuwait for ASD) work with ASD, thus, infused it into the curriculum-- his professional "niche"

Never was if you have A then do B, however, ASD was brought into the discussion of the class (incorporate/infused ASD)

Covered ABA principles in class

Enjoyed the personal experiences he shared with the class, what he struggled with as a parent

Taught them an “attitude of respect” and getting the families perspective of their experience

- “teach me about you”
- person-centered counseling
- recognizing the child’s strengths

Assignment: hearing teacher and peers’ narratives regarding the dx had an impact on her remembering specific information: 1) their experience with ASD as a parent, 2) need for support and community as a parent with ASD

Taught the class: identified resources, open the conversation and dialogue in class, and encouraged more training

#### Post-graduate experiences:

##### *Family work*

Encourage families to do their own research; bring it back and discuss in session

Provide psychoeducation, normalize experience, work on attachment and refer out where they could get “more help”

Sometimes getting the dx is a relief, but parents must grieve as well as move past the dx

Processing grief

Normalizing experience

Support groups in the area for parents (refer to these)—Giving them a community of people that can support them (validate experience, empathize, understand their perspectives)

Get parents to understand the dx so they can better understand their child and respond appropriately

Get them to understand their child and celebrate their uniqueness

Important to address the family system

Realigning counselor's expectations as well as families

Address family dynamic if inhibiting growth

Teaching them interventions (family and IP)

Skills: listen, reflect, slow down, model appropriate bx, and create a safe environment where the child and family can feel safe

Assign readings that are developmentally appropriate for families to read and go back and process what they read

### *Individual*

Worked with HFA bc must be able to engage in some form of talk therapy/play therapy to bill Medicaid

Building rapport and person-centered approach: Truly understand what the child needs and are communicating

Assign readings and reflect back to see what part of the information “fit” with the child experiences

Even though she didn't see herself as an expert, would point them in the right direction where they could get help



Be open to the child teaching you- Person- centered approach

*Supervision:*

Differential dx

How to manage bx

Careful to dx ASD because they did not have a battery of tests—Takes dx seriously

because of ramifications for the dx (life)

Would feel like an expert if she had an objective measure she could use (battery of tests)

because observation is not enough

*Bigger issues:*

Injustice of not being able to see the child unless they have a secondary dx

Must be an advocate (for more services, recognizing needs, recognizing injustice,

questioning dx and helpful for the family)

Medical model [sick model] versus the needs of the families and children with ASD

(conflict). Children with ASD will not be cured

Balance between MFT identity and the medical model

Must understand scope and refer out

Need mentor to provide wisdom and who is available on the dx

Participant educated herself, bought books

Willing to learn and continue to learn

Believes there is a benefit to not feeling confident and wanting to be effective... continue

to learn, educate herself .. Thus, being more open to hear the client's story and the family

Need formal training in ABA, but had exposure to it in class (knows the basics),  
however, not wired to do ABA because she loves the relational piece to counseling  
("helping parents take that insight and then moving forward")

Don't necessarily need to know ABA

Life experiences:

- 1) Has her own MH dx (ADHD)- increases her awareness because of her own "struggle,"  
feeling misunderstood
- 2) Dad was a pastor: worked with special needs people in the church and classroom.  
Exposed to persons with disabilities. Learned to be gentle, kind, and not afraid of  
working with persons with disabilities
- 3) Babysat a child with ADHD and enjoyed it
- 4) Undergrad in Equine Business Management: Worked with children with disabilities  
and loved working with them

Assumptions/biases:

They are all really intelligent

The child is going to be combative and display bx in session

They are always going to need help and they can't be successful

Now doesn't expect to see things, but waits until she observes them.

Critical:

- 1) not to assume they don't have any feelings (have "rich emotional experiences")
- 2) It may look different, but doesn't mean they don't have any emotions and can't  
have close relationships 69

**Emily:**

*In vivo and structural coding*

Educational experiences:

“Touched on it a little bit but to be honest, they don’t go into it a whole lot”

DSM class: Mostly just clinical diagnosis and diagnostic criteria

Undergrad: developmental psychology course

Would have been helpful to discuss treatment options (interventions) and what you do as a counselor

Would have been helpful to discuss differential dx

Life experiences:

During grad school, got a job at the clinic working with ASD

- walk you through behavioral analysis
- Bx: decrease aggression, increase basic functioning, educational setting, learning new skills, socialization
- Engaged in team meeting every week
- Educating them every week depending on the needs of the child: reinforcement scheduling (style was teacher: student)—must be coachable
- Learned it is very objective treatment to ASD: step-by-step function of bx
- Very black and white, which was helpful at the beginning of her development to increase her expertise in the area (“concrete explanations”)

Post-graduate experiences:

Hired for her background in ASD and licensure

Dual diagnosis clients needed treatment and needed a counselor to treat them

- had to work out how to assess them appropriately to see if they were appropriate for treatment
- “Taking a look at their history and then what sx appear to be above and beyond what would be accounted for by and ASD dx” line 197-198
- bx were worked on in residential and she worked on inter/intrapersonal skills
- “hard to tease out” dx and working with these clients to improve treatment outcomes
  - “Trial and error”
  - Research on the internet
  - Flexibility in session (“thinking on the fly”)
  - Creativity in session (“hands on techniques working with them”)

### *Individual*

#### Skills (Techniques)

Setting up a routine (schedule for session, predictable)

Build rapport

Pull on their interests and bring into session

Bringing in humor and if they understand sarcasm

Creativity- not talk therapy, but finding a different way to probe

Directive counseling

Assess if they can relate feelings to themselves or not, if not use third person

Bring objects and props (re-enact stuff)

Behavioral techniques are helpful to move the session along

Collaborate with other clinicians and family

Helpful to *observe* them

*Personality:*

Being proactive (“It takes a lot more work than the average client”) and motivated to do the work

Has a lot of radical acceptance (simply accepts the way she is and the way others are)

She is very coachable

Thrives on feedback and critiques and continue to develop as a counselor

Humanist

*Family work:*

Lack education around what they are doing and what they need to do with their child with ASD

Processing through frustration, realigning expectations/timeline to treatment outcomes, grief and the unknown

Bx training: rules, expectations, and routines in the home (“constant structure and routine”)

- understand the value sx of the home and what is realistically going to work for them
- Meet them where they are

How to relate to their child a little better

*Supervision*

Collaborative

Validation and feedback

Has peers she can take issues to from all types of disciplines and “bounce ideas off of”

Assumptions/Biases:

Prides herself on being able to work with just about everybody

Life experiences:

Always worked with kids her whole life

Critical:

“Have to have a lot of patience... Must be a patient person”

Counselors must be willing to celebrate baby steps

Must not be critical when the progress is not apparent (realign expectations?)

Must be aware of self and body language (very receptive)

*Other:*

Counselors struggle when there are bx in session and how to respond to it appropriately

- need to have an understanding of ABA
- must understand the function of bx

Working with the diagnosis is intense

HFA is going to benefit from individual counseling 58

**Hillary:**

*In vivo and structural coding*

Educational experiences:

Took abnormal development (talked about working with persons with disabilities)

Undergrad: learned about ABA (trained under Lovaas)

Practicum and Internship (school): worked with families and children with disabilities

- always ran groups that included students with disabilities

- connected with the teachers that worked with students with disabilities
- mindful of including them because other people would not
  - o recognized students with disabilities needed to resources more
- had a mentor during this time that was open and embraced her ideas of working with these students
  - o taught her to always expand the system
  - o reach all parts of the system (meso perspective)
  - o social justice perspective
  - o “reach as many people as possible who are in need”
- inclusive practices

#### Life experiences:

Recognized that these kids were “ignored” and try to befriend them

“empathic”

- innate part of who she is
- parents didn’t put people in categories
- always encouraged to help
- older brother was very thoughtful
- church influenced this
  - o everybody was accepting

Was a caretaker for a child with ASD

Son with a disability

- son has friends who have ASD
- exposed to a parent group who have children with special needs every week

Post-graduate experiences:

Recognized as the “go-to” person for students with ASD (school and family intervention services)

Increased knowledge by reading literature, going to workshops, conferences

“trial and error”

- first our something that would work for one family/student and would try it on another; however, aware interventions needed to be individualized

First time she worked with the client displaying bx, felt incompetent, but once they worked through it, it built her confidence

Dual-diagnosis: whatever the presenting problem is, that is what you focus on

*Family work*

Making sure they don’t feel isolated

Connect them with resources

Normalizing the experience/feelings

Looking at the needs of the family and assessing what that family can realistically do

Meet the family where they are

Making sure goals are achievable

Assist them in moving forward

Increase expectation of the child

Develop a supportive environment

Reframing the problem

Parents and children need support

Never make assumptions



- must challenge your assumptions (i.e., “someone who is on the spectrum isn’t very smart”)

Humanist: “you don’t walk in thinking you know everything about the client”

- must be open to listening, hearing, and discovering more

Understanding the system and what they are capable and not capable of doing

Humanistic perspective- working *with* the family

Social justice and Advocacy very important

- gained confidence by just doing it and knowing it was the right thing to do
- using counseling skills to ease tension
  - o counselors have the skills to do this work
- having “intentionality” behind it
- feeling uncomfortable should not be a barrier to helping

Important to know you may not have all of the answer but as long as you are trying, reaching out for help/guidance; counselors can be effective with treating the dx  
ABA gives you confidence and exposure to ASD, but it does not teach you to do counseling (“two different worlds”)

- using certain tenets of ABA can be helpful

#### Assumptions/Biases:

Assumed children on the spectrum had zero social skills, “absolutely not true”

#### *Counselor Education*

“education period about the population promotes you being more willing and able to work with the population”

- multicultural immersion activities—promotes a new concept

- increasing exposure helped counselors-in-training
- exposure is vital

As a teacher, she normalized the dx, guide students to resources, provide support when seeing clients

Practicing inclusion in counseling

Critical:

“They’re human, so listen to them” 73

**Bobbi:**

*In vivo and structural coding*

Educational experiences:

Did not receive any educational training

Needs to be more CEUs on ASD

Post-graduate experiences:

Media talking about it more (i.e., ‘Parenthood’)

Daughter is in special education and shares information with her from her scope

- learn from her when she talks about kids and families

Actively sought out reading on ASD

- eager to learn and continue learning

Firsthand experience is the best way to increase competence

No protocol to treat ASD; each person is unique

Individualized treatment is important

Uses Upworthy: Inspirational and educational

“Meet them where they are”

Work with their strengths and abilities

Person-first perspective

Comfortable speaking up for injustices

### *Individual*

Provide psychoeducation (using videos in session to process)

Providing clients with resources is helpful

Relieving to have a name for what is going on

### Life experiences:

Thinking back, classmates may have been on the spectrum

Always had a “sensitivity” to people who were different or had a disability

Mom’s values: Instilled in her to treat people with dignity and respect

- taught her about social justice issues (MSJCC perspective)

aware and sensitive to other peoples’ needs

### Assumptions/Biases:

“You are given gifts and abilities and you know, you’re responsible to use those and share those to benefit other people” – used power in a productive way 24

### **Toni:**

*In vivo and structural coding*

### Educational experiences:

“Not at all.”

Took a “special needs class” (similar to multicultural counseling class) and they talked about disabilities

GA she had in graduate school made her fall in love with the population (Working at the Center for Autism and Related Disabilities [CARD])- engaged in support groups there

Internship at CARD:

- working strictly with ASD in internship
- shadowed persons from other disciplines

Post-graduate experiences:

Challenge: disconnect between ASD and the counseling profession

- if you put in effort and work, can see the progress

On-the-job training

Liked working with population because it was a challenge

Must collaborate with client and family

Did her own research

Learned most from her colleagues

Therapeutic relationship (hallmarks of our discipline)

Come from a strength-based approach

“Mentors”: network and connected with people from other disciplines that taught her a lot about ASD (special ed, SLP)

- getting their perspectives was really helpful to increase her “breadth of knowledge”

Infused ABA into her treatment and learned the principles of it.

- felt comfortable teaching families about this as well

Counselors are able to treat the co-morbidity of the dx

- look at primary, secondary, and tertiary dx... what is having the most impact on the presenting issue
- harder to work on the ASD when they have other presenting issues
- not super helpful to process the roots of the issue (i.e., depression and anxiety)
  - o need to provide very concrete, black and white treatment (directive counseling, CBT, ACT, positive psychology) ... try to collaborate as much as possible

“critical” to have a multidisciplinary approach

- important to have this approach because it is a developmental disability

Should use behavioral interventions with clients (evidence-based) ... It's our responsibility to broaden our scope

- bringing what counselors can do and BCBA's can really be helpful for those with ASD
- must collaborate
- bx techniques “complimentary” to counseling work
- “theoretical rigidity” not good, must be willing to integrate perspectives

Ran a young adult support group—help them make social connections

Confusing to work through overlay of MH and Rehab counseling (“identity crisis”) until she felt comfortable identifying she was a counselor and this is what she can bring to the table

- MH doesn't feel natural working with disabilities; however, we can promote the counseling profession and share what we can add to the treatment of ASD ("creating a bridge")
- Showcase our strengths as counselors ("Value our specialization")
- Look at similarities between disciplines and opportunities to collaborate

### *Supervision*

Having supervisees involved in researching information, shadowing, training, and workshops

### *Family work*

Ran a Mommy and Me group (parent assisted treatment group)

- training program where they help parents, facilitate the bond process, help them communicate verbally, work on bx's

Must understand family systems

Must understand dynamic and the family's expectation with ASD

Psychoeducation ("un-teaching" things)

"Process the emotional impact of having a lifelong dx"

Counselor as "model"

"Coaching"

Acknowledging frustrations and emotional reactions

Grieving process; however, sometimes families are relieved to have the dx because they have a name to what is going on and can work towards treating it ("optimistic perspective")

### *Counselor Education*

Methods of instruction: clinical examples and what she has seen in treatment

Try to infuse ASD as much as possible (multicultural and didactic courses)

Difficult to find field work on this population

Implications for CE: expanding cite placements

Assumptions/Biases:

Low SES, LFA, parent had a disability... tallying all of the indicators of a poor prognosis and assumed she would have a difficult time incorporating interventions at home... when prognosis was getting better, realized the “potential of the family” and not to discredit someone who may have some disadvantages

Assumed working with disabilities was work rehab counselors did

Life experience:

Disability was so foreign to her she never thought she could work with it and was happy she was “disproven”

Critical:

Get exposure

Fieldwork experiences are going to build one’s expertise

Working with ASD is not for everyone

ASD is personally and professionally rewarding—hope opportunity is awarded to more people (Line 585-589) 65

**Jean:**

*In vivo and structural coding*

Educational experiences:

Art Therapy:

Two methodologies- 1) mind to mind processing and 2) creating opportunities for an outlet (relaxation)

Can read something in a book, but hands on experience is so important

“there were not a lot of classes that I took that specified autism”

Practicum: worked with ASD so she could go outside of her norm/ “comfort zone”

- Supervision in ASD
- Passion for ASD started here

Internship: Agency she worked at investing in the dx and taking more clients with ASD  
(focus of services at agency)

Worked in the group therapy department

- mindful of expanding services to those with ASD
- large learning curve, but realized “art was an option for everyone”

Picked up time outside of internship to learn more about ASD- proactive learning about the dx?

- educate herself across the spectrum so she could better understand the dx and tx
- shadowed so she “could better understand the students” who are non-verbal
- Goal: could be as simple as engaging in art, staying on task, and sitting with peers; However, developmentally, everyone would need to be at the same level for it to be productive

*Realized:*

It was important to meet the client where they are



Understand what they benefited from and where their challenges were

Humanistic approach

Post-graduate experiences:

Cottage supervisor for children with ASD

- every part of their day needed to have some structure
- visual supports built in
- engaging in different ways of communicating with clients, using assistive technology, signs

Dual-dx complicates treatment

- differential dx confusing for people and need to focus on both instead of just one
- spend time sifting through it, but not become hyper focused on the ASD
- case example: outlandish bx that were actually sx of HFA
- She goes back to the most basic strategies and supports we put in place for kids with ASD and make sure that those things are available to these kids and see how it works (typically reduces bx that get in the way of tx)
- Make sure they understand their day and expectations
- Sifting through the sx to understand the root of the bx
- If HFA, have them “create those expectations” with you
  - o Understand developmentally they may be resistant because they are a teenager
  - o “Try to treat them as stereotypical as possible but also delve in the supports that they need for their deficits”

- Use visuals
- Structure important
- However, with this dx, quick to reference other dx... Have to look at the client holistically (Look at them from a biopsychosocial approach)
- Have you tried everything you know what to do with ASD and when do you decide it becomes a secondary dx
- If there is bx, ask: “does he understand how long he is going to be doing this? Does he understand how many towels he has to fold? Does he understand when it is gonna be over?... decreases anxiety and helping them feel they have appropriate ways to communicate (functional communication and coping skills)
- Use praise when engaging in appropriate bx (need motivation)—making sure the motivation is meaningful, changing with them and their needs
  - o Person-centered, humanistic

Beneficial to collaborate with people from other disciplines

- multidisciplinary approach and collaboration: Best-practice
- does take a lot of time to engage in a multidisciplinary approach
- appreciates their scope, perspective

Treatment goal: build up their resilience so they can manage everyday situations/life

Important to build rapport and taking the time to understand clients and why they do the things they do versus observing them all the time

- “These kids build relationships, they build trust, they depend on people, they know who the people are that are going to keep coming back and showing up and meeting their needs” Ln 322-324
- They excel with a consistent relationship

Being creative: “outside of the box tools”

Must look at the client and family holistically (family systems perspective)

- ppl quick to blame the family, instead partner with them
- Humanism: trying to understand their reality
- Person-centered
- Advocating for the families

Must recognize resources in the community, agency, etc. one can refer to

Mentors have been very important in her development: Challenge her to think differently about things

- getting other specialty areas perspectives
- reciprocal process

### *Supervision*

Recognizing you are probably doing what the child needs; re-align expectations;

encourage outside counselors to come to clinical rounds; important to share information

### *Personality*

Try to be incredibly optimistic

Never give up

Creative

Never stops learning or asking questions

Likes to problem solve

Wants to be involved with implementing idea and following through on it

Takes feedback and does things differently next time (tx)

Critical:

“Take your time, build a relationship, don’t make assumptions, and gather all of the information”

Get the whole picture of the child and collaborate if you can’t get the information 75

**Anthony:**

*In vivo and structural coding*

Educational experiences:

Undergrad: Took an elective class on ASD

- discussed ABA, bx principles and how its affective with ASD

Exposure in undergrad to ASD and professor sought him out to see if he would be interested in learning more

Knew the dx was growing and wanted to be prepared for the psych field

Graduate: went to a couple of workshops and presentations on ASD, but no formal class

*Personality:*

Had a motivation to learn

Life experiences:

Heard about working in residential when he was in his grad program and applied to the job

- anxious about working with bx of clients with ASD

- Realized ASD looks a lot different in person than on paper
- “Learn as you go”
- Working on the floor taught him the real meaning of *patience* and understanding
  - “learned patience through my work experience more so than I’m a naturally patient person”
  - having a “client-centered approach” (taught in graduate program) was key to develop the patience and understanding required: graduate school provided him the framework and principles of person-centered approach and truly learned patience when he started practicing
- be able to read a situation, understand, and respond appropriately
- must build a relationship to have success with this population

Post-graduate experiences:

Group therapist:

- established motivators, reinforcement
- Facilitator – heavily involved with keeping the group going
- Group members with ASD need prompting to connect with others
- Use their “preferred interests to draw out conversation” and relate it back to the social topic that was being discussed
- Use active listening
- Having patience
- Be able to identify triggers and threshold for the counseling process (“tolerate”)
- Celebrate the small successes

- Re-align expectations

“If I was a counselor fresh out of the program with no experience on the spectrum, I would probably have different expectations [for counseling] and be frustrated. Their progress is comparatively miniscule; however, with expertise in work with the clients, I think the little progress that they do make is a huge deal”

Humanist: understanding where the client came from and having them respond to treatment is really rewarding

Knowing some of the basic tenets of ABA (“source of strength”)

“Important to know different approaches”

### *Family work*

Increase knowledge about the dx

Validating their experience

Incorporate visuals and structure (family)

Worked through grief

Realign family’s expectations of what the child can and can’t do

Some families not as receptive to the process

Collaboration on goals

Challenge them

### *Supervision*

Important to have someone guide you, prepare you for what to expect, how to intervene, and how to be successful

Get supervision from someone who has been through it and seen what you see in tx

Must be a coach (through situation), challenged, different ways to think about the client, traditional therapy and what it should look like with ASD

Critical:

“You’re going to family and you’re not going to feel like you’re making progress but, you have to keep pushing through”

“Don’t give up, keep going, keep doing what you’re doing to help the client.” 42

**Simon:**

*In vivo and structural coding*

Educational experiences:

No impact on specific ASD information

- didn’t feel prepared to work with ASD sx

DSM and tx planning class helpful

School had “Rogerian bend;” thus, principles honored and recognized the individual as a person

Program addressed family systems, which “informed” tx

May be helpful/valuable to have ABA training as an elective course (advocates for this)

Post-graduate experiences:

Gone to conferences

Done his own research

Recognized overtime the injustices of the dx

ABA provides a “fundamental road map”

- objective approach versus “throwing stuff out and seeing what happens”

- Have a foundation, “soft training”
- Superimposing ABA and what comes natural to counselors
  - o Counselors understand the human condition (grey)
- Rogerian and CBT insufficient to work with ASD
- gives you a theoretical basis for decisions (LFA)
  - o Need scientific, empirical approach to work with LFA

“Trial and error”

Rapport building important

Person-centered (therapeutic value in this)

Holistic perspective

“Think outside the box”

There is a level of sacrifice to help other and create systems that support this

Counselor must be a good listener, understand challenges, and support the family

Counselor characteristics: compassion, attentiveness, and presence

Counselors need to examine the “boundaries that govern the counseling relationship” and engage in SJ, advocacy and even case management services

- traditionally, counseling may fall short in addressing the population
- flexible
- going outside the office
- profile of ASD atypical and may not be conducive for my traditional models

expertise= “develop whatever knowledge base I have”

- “firsthand knowledge”
  - o partnering with other disciplines, partnering with parents



- Exposure to dx over the years
- Exposure to other disciplines
  - Multidisciplinary approach has been helpful
  - Valuable input
- understanding a family systems perspective
  - how systems impact individuals

Existential/Rogerian approach with individuals

Learned assessment, types of interventions, visuals have all benefited from experience

*Family work*

Psychoeducation (parents and siblings)

Counselors can transform systems

Can “provide a different frame” that is friendly, compassionate, humanize the treatment

Counselors can decrease tension and communicate with parents in a different way

Facilitating acceptance

Facilitating communication (“common language”)

Family shift approach

Normalize family experience

Work collaboratively

Education family on the interventions

*Individual work*

Help client identify and label emotional states

Assist with grieving dx

Coping strategies to prevent escalation (objective, non-abstract strategies)

Empathy training (increase understanding of family experience or how bx impacts other people)

- didn't lack empathy = ASD deficits instead

Work collaboratively

Empowering client to use his voice and getting family to honor it

Person-centered approach

Soft skills training

Powerful role with HFA

CBT: use tools/interventions with ASD

### *Supervision*

Offer his experiences to supervisees

Challenging supervisees to think differently about client

- not “compartmentalizing” or labeling client
  - o taking away the label, what would you do differently?
- Think more “globally”
- Walk in their shoes
- Increase empathy
- Trying to provide/gain perspective
- Important to play devil's advocate

### *Personality*

Humility and modesty

Hesitation to label because there is still so much to learn about ASD

Natural tendencies and understanding, intuition

Assumptions:

Acknowledge his own struggles and humanness in the counseling experience

Not labeling himself an expert

- not “victim” to thinking he knows all the answers
- not putting people into boxes

Medical model: must cure. However, can’t do this with the dx

Initially thought if you have ABC and D then optimal functioning

- however, imperfection is ok
- inevitable to have imperfection of the systems
- “life is messy and resources are limited”
- Can’t always push client to fit into “normal human being” label

Not judging system too harshly

Residential tx (well-oiled machine)—when they leave, the setting they live in will not

“emulate” that; thus, not setting individual up for success

Parents have taught him to accept the child’s deficits and don’t expect the child to change fundamentally

- what is truly realistic
- pushing client, but accepting their limitations
- accepting the child for who they are

Own life: systems aren’t perfect and distrusted them

- thus, create a system that is transparent, as well as collaborative
- showcase client and families voice

Critical:

MCSJC training important to work with diagnosis

Not everyone's experience with ASD is going to be the same

- this training will inform our understanding of ASD

There are general themes across ASD, but not going to be the same

Competencies in the area of ASD will be important because more counselors will be working with the dx and the dx will continue to rise 100

## APPENDIX F – SECOND CODING ITERATION

### **AWARENESS:**

“INSIDER STATUS” Child has a disability – John, Hillary

Participant and Family member may be on the spectrum, disability, MH dx (A) –

Florence, John, Elizabeth, Douglas (brother), Jannell (cousin), Mel, Kaitlin (two cousins)

= 7

PERSONAL EXPOSURE: Exposure to disability growing up (neighborhood kid, family

friend; A) – John, Kaitlin (“higher tolerance for acceptance”), Douglas (what

interventions were helpful for his brother), Mel; (church, equine therapy), Hillary

(Recognized that children with disabilities were ignored and tried to befriend them,

church accepting, caretaker for child with ASD), Bobbi (classmates) = 6

FAMILY UPBRINGING: Did not “label people” (A) – Kaitlin (always taking care of

someone, parents endorsed acceptance), Douglas (“as a person of color, was taught it

“doesn’t matter what they’re dealing with or what they look like”), Hillary (parents did

not put people into categories), Bobbi (treat people with dignity and respect,

“sensitivity”), Mel = 5

“BALANCED PUSHING AND ACCEPTING”: REALIGN EXPECTATIONS

(counselor) – Florence, Douglas (critical), Jannell, Mel, Emily, Anthony (Celebrate the

small successes, quote) = 6 (post-graduate)

SCOPE OF PRACTICE: Important to understand scope/ “limits” – John, Kaitlin (LFA),

Elizabeth (resource out; ex bx), Douglas, Jannell, Mel, Hillary = 7 (post-graduate)

## ASSUMPTIONS AND BIASES: = 7

- Didn't want to work with ASD because it was too intense – Anthony

High SES will have a better understanding of interventions, but all families are lost (A) –

AMT

Challenges working with the parents and child – Jannell, Florence

LFA: child can't engage in counseling, but once built rx, child's personality came

through – Jannell

They are all really intelligent – Mel

The child is going to be combative and display bx in session – Mel

They are always going to need help and will not be successful – Mel (now doesn't have any expectations, but waits to observe everything)

Children on the spectrum had zero social skills (A) - Hillary

Case example – Toni (learned not to discredit anyone) (A)

Working with disabilities is what rehab counselors did (A) – Toni

Working with persons with disabilities was “foreign” to her, but glad she got the opportunity (A) – Toni

CHALLENGING ASSUMPTIONS AND BIASES= 7 Elizabeth, Hillary (quote) (post-graduate)

- It may look different, but doesn't mean they don't have any emotions and can't have close relationships (actually have “rich emotional experiences”) – Mel (critical)

- “Not being able to speak is not the same as not having anything to say” –

Elizabeth

- Must have ABC and D and everything will be perfect, but realized imperfection is OK and inevitable in systems (A) – Simon

- Mistrustful of systems growing up; thus, transformed systems he is in charge in to be transparent and collaborative (A) – Simon

- Must be aware of non-verbals/body language (A) – Emily (critical)

- Awareness of not stigmatizing children with ASD – Kaitlin

- Media talking about it more (A) – Bobbi

- Awareness of difficulties parenting a child with ASD (A) – Jannell

CLAIMING NO ASSUMPTIONS OR BIASES: (family upbringing)

No, but acknowledges she may have had a reaction, but unintentional – Kaitlin, Douglas (no, but doesn't make him an expert), Emily (prides herself on being able to work with everyone), Bobbi (no, respected everyone) = 5

### **KNOWLEDGE:**

EDUCATIONAL EXPERIENCES: Undergrad: Introduction to Learning Disabilities – Kaitlin, Emily (Developmental psych course), Hillary (abnormal development; trained under Lovaas= ABA), Anthony (Elective class on ASD, ABA principles) = 4

Graduate: “No educational training... outside of diagnosis class [K]”- Florence, AMT, Elizabeth (none), Douglas (DSM), Jannell (critical to know the DSM), Emily (quote, DSM), Kaitlin (DSM), Bobbi (none), Toni (none), Jean (none), Anthony (none), Simon (DSM and tx planning class) = 12

Professor (personal and clinical experiences) infused ASD (K) – John, Mel

- covered ABA principles (K) – Mel

- Helpful to hear instructor and peer (special education) narratives (K) – Mel, Kaitlin

APPLIED BEHAVIORAL ANALYSIS: Important to understand tenets of ABA (i.e., reinforcement, LFA; K) – AMT, John, Douglas, Emily (when bx present in session), Hillary (can be helpful), Toni (we must broaden our scope), Anthony (“source of strength”), Simon (“fundamental road map,” theoretical basis for decisions [LFA]) = 8 vs. ABA not necessary to know as a counselor – Jannell, Mel (need formal training, relational piece), Hillary (“two different worlds”) = 3

“COLLABORATION”: MULTIDISCIPLINARY APPROACH – AMT (quote), Elizabeth (critical), Emily, Toni (critical bc developmental disability), Jean (team approach, best-practice), Simon (valuable input), Mel = 7

- counselors focused on feelings/emotions – AMT
- Can “provide a different frame” that is friendly, compassionate, humanize the treatment, decrease tension – Simon
- Look for similarities between disciplines and opportunities to collaborate – Toni
- Vulnerable and ask questions – Kaitlin (line 157-158)

MENTORS: Talking with colleagues (“model, mentor”), feedback – Florence, John, Kaitlin, Elizabeth (critical; mentor; Significant other resource), Douglas (model, feedback; “help guide his work”), Jannell, Mel, Emily (peers from other disciplines), Hillary, Bobbi, Toni (mentor; quote), Jean (other disciplines perspectives, mentor), Simon, Anthony = 14



- Colleagues “helped see different aspects of the whole person to conceptualize the client” – AMT, Elizabeth, Toni (shadowing) = 3

#### NECESSARY KNOWLEDGE SETS (Individual):

Traditional counseling can’t always be implement with ASD – AMT, Toni, Simon,

Evidence-based practices – Jannell

Diagnostic Criteria: = 6 Persistent deficits in social communication and social interaction across multiple contexts and restricted, repetitive patterns of behavior, interests, or activities. Minimal eye contact – Kaitlin, difficulty articulating feelings – Kaitlin, mindful of sx and understanding triggers – Kaitlin, Anthony, communication issues/functional communication – Kaitlin, Jannell, Jean, sensory issues – Kaitlin, understanding the child’s needs and development – AMT, Florence, Jean

Must prepare ASD client for the real world and if everything is perfect, setting them up for failure – Simon (quote), Jannell (Push so child does not become “stagnant”), Kaitlin (bubble)

- “Exhausting,” “intense” working on something over and over again (K) – Jannell, Emily

#### NECESSARY KNOWLEDGE SETS (Family):

Family systems background/approach “see the bigger picture” – Jannell, Mel, Hillary, Toni, Jean, Simon, Emily, Elizabeth (learned in graduate program, we can “transform systems,” “not to judge systems too harshly”) = 8

- Understand family dynamics – Jannell (how to implement interventions), Toni
- Family work can be very challenging, skills can be tested – AMT, Jannell (“treat lightly,” “resistance”), Anthony

- “let go” of the caretaker identity – Jannell
- Evidence-based practices – Jannell
- Dx may be a relief – Mel, Bobbi, Toni (“optimistic perspective”)
- Reach all parts of the system (reach as many people as possible who are in need) – Hillary

### **SKILLS:**

“TRIAL AND ERROR”: “Actually doing the work,” “on the job training” –Florence, AMT, John, Elizabeth (quote), Bobbi (firsthand experience), Toni, Jean (hands on experience), Anthony (“learn as you go”), “Trial and error” (S) –Emily, Hillary, Simon = 11

- Built confidence through working through bx in session (S) – Hillary

### **NECESSARY SKILL SETS (Individual):**

**ASSESSMENT:** Co-morbidity (S) – Florence, Jannell, Emily (quote), Hillary (whatever the presenting problem is), Toni, Jean, Mel = 7

- know tx for all dx and combine (K) – Jannell
- Tx MH dx first, if ASD was first, get baseline functioning (S) – Florence
- Look at primary, secondary, and tertiary dx (what is having the most impact) (S) – Toni
- Need to treat both – Jean
- Uses basic strategies and supports to for ASD to decrease bx so it does not get in the way of treatment (S) – Jean
- Try everything you know to treat ASD and if nothing changes, may be a secondary dx

“Take your time, build a relationship, don’t make assumptions, and gather all of the information” – Jean (critical)

#### COUNSELING APPROACH:

Personalize/Individualized Treatment – Florence, Kaitlin, Jannell, Hillary, Bobbi, Jean, Simon, Douglas (“Every case is unique”) = 8

- There are general themes across ASD, but not going to be the same – Simon (critical)

Collaborate with client – Florence, Toni, Jean (HFA), Simon

- treat them as stereotypical as possible– Jean
- Giving them a voice, self-advocacy (S) – AMT, Kaitlin, Simon (family honor it)

Play therapy- Florence, Emily

Bibliotherapy – Florence

Group counseling – Kaitlin, Toni, Jean, Anthony, Florence (lego group) = 6

- Facilitator – heavily involved with keeping the group going – Anthony
- Group members with ASD need prompting to connect with others – Anthony
- Use their “preferred interests to draw out conversation” and relate it back to the social topic that was being discussed - Anthony
- Assess appropriateness for group work – Toni

Directive counseling –Emily

“Black and white treatment: Directive counseling, counselor as model, CBT (Simon),

ACT, positive psychology – Toni, “Being very concrete” – Florence

Psychoeducation – Bobbi, Mel

Art therapy (two methodologies, “art an option for everyone”) – Jean, Elizabeth, Kaitlin

SPECIFIC “TOOLS”:

“Tinker objects” (“sensory bin”) in office—keep their hands busy – John, Kaitlin

Social stories – John, Kaitlin, Elizabeth, Florence

Observation (non-verbals) – Jannell, AMT, Toni, Jean (quote), Emily = 5

Identifying coping strategies (non-abstract)– Mel, Simon

Setting up routine for the session (schedule, predictable, structure, expectations) –Emily,  
Jean

Infuse their interests into the session (“buy in”) –Emily, Anthony

Visual supports, PECS – Florence, Kaitlin, Elizabeth, Jean, Simon

Behavioral strategies: Reinforcement, make sure it is meaningful, motivators – Jean  
(quote), Anthony, AMT, Kaitlin, Emily, Toni = 6

Can they relate feelings to themselves, if not, use third person –Emily, Simon

Providing resources - Bobbi

NECESSARY SKILL SETS (Family):

COUNSELING APPROACH:

Giving family a voice (“allowing them to have a role and input in the process”) – Jannell,  
Anthony, Simon

Psychoeducation (+ siblings) – Florence, AMT, Kaitlin, Douglas, Mel, Emily, Toni,  
Anthony, Simon

Greif counseling (facilitating acceptance) – AMT, Elizabeth, Emily, Hillary, Toni  
(“process the emotional impact of having a lifelong dx”), Anthony, Simon, Mel, Douglas,  
Florence (“can’t fix them”) = 10

Collaborate/partner with family – Toni, Jean, Simon, Douglas

**SPECIFIC “TOOLS”:**

Teaching interventions (bx, in home structure, what is realistic for the home environment) – Florence, Douglas, Mel (respond appropriately), Emily, Hillary, Toni, Anthony, Simon = 8

Adjust/Realign expectations – AMT, Douglas (“buy in”), Mel, Emily, Hillary (increase expectation of the child), Toni, Anthony, Simon = 8

How to relate to their child better, increase bond, facilitating communication so there is a “common language” – Simon, Emily, Toni, Mel = 4

Gaining access to resources can be difficult, but must connect families, support groups (“team/community of people around them”) – AMT, Douglas, Mel, Jean, Hillary = 5

Encouraged families to do their own research, assign readings – Mel

“Coaching” – Toni

**COHESION- AKSA:**

“EXPOSURE”: Practicum/Internship/life experience experiences increased confidence (AKS) – Florence, Kaitlin, Emily (CC), Hillary, Toni (as a teacher, acknowledges it is difficult to find fieldwork on the population= implication, CARD), Janell (ABA line therapist), Jean, Anthony (residential) = 8

**ACTION:**

Must engage in Advocacy and Social Justice issues (MCSJC) – Elizabeth, Mel (secondary dx), Hillary (mentor, examples), Bobbi (mom taught her this), Jean, Simon =

“You are given gifts and abilities and you know, you’re responsible to use those to benefit other people” - Bobbi (CE; used power in a productive way)

-Counselors need to examine the “boundaries that govern the counseling relationship” and engage in SJ, advocacy and even case management services – Simon

- traditionally, counseling may fall short in addressing the population – Simon
- going outside the office – Simon

### **COUNSELOR IDENTITY:**

“Passion,” understanding and wanting to help – Florence, Jean, Kaitlin (compassionate), Simon

Empathic: “Empathy still counts, but would translate it to kind patience” – John (critical), AMT (empathy), Janell, Mel, Anthony, Simon, Kaitlin = 7

Presence: Hearing, listening, and discovering more – Hillary, Simon (attentiveness), Kaitlin, Elizabeth (quote) = 4

Learned a client-centered approach” in program (framework for counseling); however, learned patience through work experience – Anthony, Simon

Advocate for the profession: “I am a counselor and I know what I can bring to the table,” “creating a bridge,” “showcase our strengths as counselors (“value our specialization”) – Toni

“We are the experts whether we have a ton a training or not... They may not have not had anyone else to explain it in a way, provide minor tips, validate, and listen” (AKS)

Baseline knowledge for counseling? We are experts, we can be helpful, we can explain in a way families and school can understand, and we have the skills and framework as a counselor to do good work with this population. --- *Don’t “discredit” yourself as a*

*counselor*. Florence, John (Be willing to play the expert to others (i.e., normalize what is going on to others) – increasing other’s awareness)

“They are fantastic and enjoyable and they will be frustrating... you’re going to be challenged as a counselor in lots of different ways, but don’t be afraid” – (AKS) Take risks. This population is rewarding to work with. Don’t assume as a counselor you can’t do this. – Florence, Toni (ASD was personally and professionally rewarding (Line 585-589)

MEDICAL MODEL VS. CLIENT’S NEEDS: Medical model versus the needs of the family and children with ASD – Mel, AMT (Client perspective vs. tx plan: A, B, C, D)

“Other disciplines very scientific, whole counselors are taught to thinking shades of gray” – AMT

Diagnosis vs. medical model – Mel, Simon (no cure)

BASIC COUNSELING SKILLS (INDIVIDUAL):

Build rapport – Florence, AMT (critical), Mel, Emily, Toni, Jean (quote), Anthony, Simon, Kaitlin = 8

Create a safe environment – Kaitlin, Janell, Anthony

active listening- Anthony, Janell

Program provided her the basic counseling skills (“tools”; S) – Kaitlin

BASIC COUNSELING SKILLS (Family):

Build rapport – Florence, AMT (critical), Mel, Hillary, Emily, Jean, Anthony, Simon, Toni, Kaitlin = 10

General parenting techniques (i.e., “token economies”) - Douglas

Supporting decision process (higher level of care) – AMT, Hillary (support)

Therapeutic confrontation – AMT, Mel, Anthony

Problem-solving to manage bx - Douglas

Normalize experience – Mel, Hillary, Toni (acknowledging frustrations and emotional reactions), Simon = 4

Validate their experience – Anthony

Listen and reflect – Mel

Reframe problem – Hillary

### **PROFESSIONAL ORIENTATION:**

HUMANISTIC PERSPECTIVE – Kaitlin, Elizabeth (“they’re human”), Emily, Hillary (“They are human, so listen to them” critical, always encouraged to help, empathy innate (LE), Jean (try to understand their reality), Anthony, Simon (“Rogerian bend,” existentialist) = 7

STRENGTH-BASED APPROACH: “abilities” (individual and family) – Florence, AMT (Look at situation and be able to identify positive/strengths (LE), Jannell, Mel, Bobbi, Toni, Jean, Kaitlin (“capabilities”), John (“Empower,” child feel important) = 9

“MEETING THEM [client/family] WHERE THEY ARE” – Florence, AMT, Kaitlin, Elizabeth (critical), Douglas (learned in school- client is the expert), Jannell, Emily, Hillary (client and family the expert, quote), Bobbi (theme quote), Jean, Mel (“Work together,” get their input, “teach me about you”) = 11

PERSON-FIRST PERSPECTIVE – AMT, Kaitlin, Elizabeth, Douglas, Mel (school), Bobbi = 6

HOLISTIC APPROACH: (biopsychosocial) – AMT, Jean (critical, collaborate if you don’t), Simon, Mel = 4



PROFESSIONAL APPROACH: Hesitant to claim competence – Florence, Kaitlin, Mel (quote), Bobbi, Emily, Jean, Simon, Jean = 8

- Benefit to this: continue to learn and educate self – Mel, Emily
- Feedback, always good to continue to develop as a counselor –Emily, Jean

Not labeling himself an expert – Simon

- not “victim” to thinking he knows all the answers
- not putting people into boxes
  - o Can’t push clients to fit into “normal human being” label

### **PERSONAL CHARACTERISTICS:**

CREATIVE – Florence, AMT, John, Kaitlin, Elizabeth, Jannell, Emily, Jean = 8

- “Think outside the box” – AMT, Jean, Simon

“NATURAL” FIT: Not every counselor can work with ASD (cognitive and need feedback, talk therapy- not “best fit”) – AMT, Florence, Elizabeth (critical), Jannell, Emily, Toni (critical), Simon (“innate”) = 7

FLEXIBLE – AMT, Kaitlin, Elizabeth (critical), Douglas (critical), Emily, Simon = 6

“TAKING ON INITIATIVE”: Research: Online, books, autobiographies research, listserv, mentors – Florence (“Figuring it out on my own” “make it up as I go”), AMT, John, Kaitlin, Mel, Emily (quote), Hillary (inclusive), Bobbi, Toni, Jean, Simon, Anthony, Elizabeth = 13

PATIENCE – AMT, Kaitlin (critical), Douglas (brother experience), Jannell (line 247), Emily (Critical), Elizabeth = 6

APPRECIATING “QUIRKS”: “Enjoyment of my own quirky-ness and finding that in others [clients]”: Rejoicing in their quirks, appreciate what makes them special –

Florence, AMT (open-minded), Kaitlin, Emily, Simon (accept client for who they are),  
Hillary = 6

GRATIFYING EXPERIENCE: Enjoyment, rewarding to see progress – AMT, Kaitlin  
 (“frustratingly rewarding”), Jannell, Toni (but a lot of work), Jean (from start to finish),  
Florence = 6

“PERSEVERANCE”: Jannell, took on challenge to work with ASD – Elizabeth, Toni,  
willing to go outside “comfort zone,” likes to problem solve – Jean, Kaitlin, Hillary  
(quote), Anthony (Don’t give up, keep going, keep doing what you’re doing to help the  
client”) = 7